Executive Summary

Phase II Sector Partnership

Saskatchewan College of Paramedic

August 13, 2007

Mercury Information Services
information for better decisions

Steering Committee

The Steering Committee was comprised of individuals from all areas of the health care sector. The participants listed below either actively participated on the Steering Committee or asked to be kept updated and receive project information.

Dale	Backlin	Saskatchewan College of Paramedics
Derek	Dagenais	Saskatchewan College of Paramedics
Charles	Eddy	Sun Country Regional Health Authority
Karen	Eisler	Saskatchewan Registered Nurses Association
Terry	Klassen	Cypress Regional Health Authority
Brenda	Fry	Saskatchewan College of Paramedics
Gladys	Hill	AEE /Institutions Branch
Iris	Penner	Advanced Education and Employment / Programs Branch
Cliff	Orriss	Prairie North Regional Health Authority
Kyle	Sereda	Spiritwood Ambulance Care Ltd.
Ron	Dufresne	Moose Jaw EMS
Tim	Hillier	M.D. Ambulance Care
Ken	Luciak	Regina Qu'Appelle Health Region - EMS
Krista	Koenders	Heartland Health Region
Wayne	Nogier	Kelsey Trail Health Region
Duane	Fleming	SIAST
Brent	Stewart	SIAST
Dr. M.	Vogel	SMA
Derek	Keller	Sunrise Health Region
Bruce	Siemens	Saskatoon Professional Fire Fighters Association Local 80, IAFF
Rob	Hogan	Saskatoon Professional Fire Fighters Association Local 80, IAFF
Les	Karpluk	Prince Albert Fire Department
Dan	Paulson	Saskatoon Fire and Protective Services

Contact Information

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Principal
Mercury Information Services
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This report was prepared for the

Saskatchewan College of Paramedics Sector Partnership Steering Committee

By

Mercury Information Services

Linda Thauberger
Principal

Disclaimer: The Steering Committee recognizes there are some statements contained in this report that may not accurately reflect the Emergency Medical Services industry in Saskatchewan. If there are questions regarding the content of this report, the Saskatchewan College of Paramedics Sector Partnership Steering Committee is available to provide information and assistance.

Table of Contents

1 Executive Summary

1.1 Introduction

Upon completion of the Saskatchewan Paramedic Association (SPA) now the Saskatchewan College of Paramedics (SCP) Phase I Sector Partnership a series of recommendations was drafted by the sector partnership steering committee to address some of the issues that were raised by the research. The two recommendations addressed by the SCP as part of Phase II are listed below in their entirety:

1. Develop and implement a continuing education model to coordinate and promote continuing education needs and opportunities in the sector. This process would include:
    - A review and enhancement of existing continuing education guidelines to meet the registration needs and the needs of employers and employees in the sector;
    - A review of current continuing education practices within all the health authorities in the province;
    - A review of current continuing education practices and standards of other professions within the province and other jurisdictions; and
    - A review of Recognition of Prior Learning (RPL) processes that facilitate the identification and documentation of experiential learning and continuing education, to the creation of professional development plans. *(to be completed at a later date)*

2. Develop a comprehensive communications strategy to support the SPA in:
    - Providing community stakeholders, employers and employees an understanding of the work that the SPA has done in partnership with Saskatchewan Health in working towards the SPA becoming a self-regulated professional body;
    - Promoting and marketing continuing education opportunities and possible funding options that may be available to support education and career laddering; and
    - Providing community stakeholders, employers and employees with an overview of the work completed and being undertaken by the Sector Partnerships Steering Committee.

These recommendations, with the exception of the final point in Recommendation 1 were addressed in Phase II of the Sector partnership project. An overview of that process, including an overview of the components and the suggested next steps is included in the following pages.

1.2 Methodology and Overview

The Saskatchewan College of Paramedics (SCP) is striving to become the regulatory body for EMS practitioners in the province. At present there are in excess of 1500 registered EMS practitioners in the province plus an additional 1750 first responders. Membership in the association is currently voluntary.

The SCP requested Phase II funding under the Job Start/Future Skills Sector Partnership Program to assist them in moving forward and implementing Continuing Medical Education to address issues identified in the Phase I Sector Study. Currently, continuing education is at the discretion of the employer and may not always be meeting the needs of the employee or the Sector. The desired outcome of Phase II will be a clear, concise, and consistent Continuing Medical Education model for this Sector.

The College feels it is crucial to develop a Continuing Medical Education model to support practitioners in acquiring the training and education needed by all EMS practitioners so that they can not only be front line emergency providers but also can complement health care partners in emergency departments, hospitals, and clinics. Through this process, partnerships with training providers will be enhanced to ensure that the appropriate training is available and also to explore alternate methods of training delivery, especially to meet training needs in the North. With this in place, all practitioners will be able to move towards common education goals following a clearly defined path. An enhanced partnership with Saskatchewan Health and the EMS sector will also work towards improved mobility of the workforce across the province.

Overview

1.2.1 Literature review

Phase I was a broad based project that identified general industry issues in Saskatchewan. Phase II will address specific issues identified in Phase I, particularly, continuing medical education. As a part of the Phase II process, a working group of industry members has been brought together to develop a new 'draft' framework for CME in Saskatchewan. To assist this group with their task, a literature review was completed. It will provide an overview of Continuing Medical Education models and practices at a provincial, national and international levels as well as interdisciplinary levels. The literature review is attached as an appendix to the final report.

Continuing Education Models – Compare and Contrast

The point of this literature review was to compile existing information (websites, existing documentation etc.) so that it could be compared to the current Saskatchewan model. This has proven to be more challenging than originally anticipated as jurisdictions differ widely.

Some jurisdictions-

- have detailed, well laid out policies and procedures.
- have policy and procedure that are being challenged to varying degrees.
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- are not self regulating, but investigating the implications of becoming so.

There is an enormous amount of information available but very little of it is standardized in its presentation. This posed challenges for development of our comparison model; What to include? What to exclude? Through an elimination process, Mercury Information Services chose an outline that is comprehensive and easily understood as a base, bringing information from other jurisdictions into that format as available and applicable.

The following definitions are provided through the Saskatchewan Ambulance Continuing Education Program and will be used to facilitate understanding:

⇒ Registration – the official act if recording a list of names, personal information and qualifications of pre hospital care providers.

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⇒ Continuing Education – a philosophical approach to facilitation professional development, ongoing training and skills maintenance.

1.2.2 Focus Group Methodology

For this draft framework to be most effective the input of practitioners was imperative. To this end, 10 Focus Groups were held (5 with Employees and 5 with Employers) throughout the province in November/December of 2006. There were 34 participants in total, 12 Employers and 22 Employees. The focus groups were held in both rural and urban settings. These included Saskatoon, North Battleford, Swift Current, Weyburn, and Regina. While the groups were held in the aforementioned locations, many of the participants drove from the surrounding areas; often in adverse weather conditions. The following communities were represented at the 2006 focus groups:

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- Colonsay,
- Biggar,
- Dundern,
- Spiritwood
- St. Walberg
- North Battleford
- Cut Knife
- Maidstone
- Swift Current
- Beechy
- Weyburn
- Creelman
- Lampman
- Gravelburg
- Regina
- McLean
- Canora

Participants for the Employer/Management groups were recruited for the focus groups from the database of service providers, industry representatives, and training providers. Employers were asked to post the focus group information to allow employees who did not complete the survey to take part in the process. Employee participants were contacted by SaskHealth direcdy because of privacy legislation. SaskHealth, as a partner in this project, sent out a letter to all licensed practitioners in July 2006. This served 2 purposes... privacy was protected and the College had an opportunity to invite practitioners to participate in this project. A consent form attached to the letter asked for contact information. Practitioners who filled out the consent form and return it to SCP were included in the database of potential participants. A professional recruiter was subcontracted by the project consultant to contact potential participants regarding the logistics of the focus groups. The process was voluntary at all times; employees were given an honorarium to compensate for their time.

It was pointed out by a participant that the groups originally titled as Employer were really owners, employers, management, and training providers. The Employee group contained employees and employees who were also representing training providers. We acknowledge that the groups comprise more than employers and employees but for ease of reporting, those will be the titles referred to herein.

During the recruiting process, effort was made to ensure that the groups were representative of the industry in Saskatchewan. The Employer/Management and Employee groups contained:

- Urban and rural representation at an employee and management level;
- Public and private and military services at an employee and management level;
- Training provider representation at an employee and management level;
- Industry representation at an employee level;
- Representation from Fire at an employee and management level.

The information from the focus groups will be summarized and presented to the sector working group to assist them in their work on the proposed CME model. A substantial amount of data was collected during the process. In order to make this stage of the process manageable, the information from all groups has been compiled; all employer groups were written up together and all employee groups were written up together. These documents were compiled into one comprehensive document.

Focus Group Summary
Following are some general observations and a brief summary of the focus group responses.

Tracking patient contacts
Most participants were in favour of tracking patient contacts but not as a mandatory part of licensing. They felt that call volumes were so drastically different between urban and rural that it would be very difficult to set benchmarks. Participants thought that tracking contacts would be very useful for Con Ed. It would allow the practitioners to identify areas where they excel and areas that require attention.

Written evaluation of skills
There was very little support for this suggestion. Most indicated that testing was viewed as a negative thing and it would make their lives stressful. Some participants (Employer) also indicated that it would add to an already heavy paper. Most felt that verbal activity and group participation were a better way to learn and assess the learners' retention.

Simulation
Almost all participants felt that scenarios were an excellent learning tool and were in favor of the more costly simulations although few had first-hand knowledge. Most participants indicated that learning required theory and hands-on experience.

Approved credit list
Participants all seemed in favor of an approved credit list. Most felt the 'approval committee' should be made up of practitioners, employers and the College. Participants thought that any member of EMS should have an opportunity to submit a suggestion to the committee providing that they could show a need. They also indicated that because different areas had different focus (fire, urban and rural, agriculture, mining and oil and gas etc.) it would be a good opportunity to expand current knowledge base. They also indicated that the committee could draft the requirements for submission.

Facilitator based model
The majority of participants were strongly in favour of the facilitator. Most participant had absolutely no desire to take on more of the responsibility for their learning and licensing requirements. Participant did indicate that it might be useful if all facilitators performed the same tasks at the same level and that standardization of the process may be useful, particularly in the more rural areas where there may not be a 'dedicated' facilitator.

Modules for CME
Participant were in favour of most delivery options but seemed to show a preference for DVD. They felt that the internet was a good resource but not all practitioners had access or the basic skills to make it really useful. Most were in favour of telehealth but few participants had experienced it first hand.

Inter agency sharing of CME information

Most participants thought inter agency sharing was a great idea. They indicated it would allow more reliable access to learning tools. Participants also indicated that it would allow sharing between agencies, particularly EMS and Fire; both of which have well developed learning process and material.

Transparent layout of requirements

Interestingly, some participants indicated that they had were not familiar with the letter that is sent annually outlining requirements for licence. Most indicated that their facilitator handled the whole situation. Of those who had experience with the letter of requirements, all were in favour of a more detailed overview of requirements including learning opportunities, their times and locations as well as mandatory and optional learning and the credit value.

1.2.3 Communication Strategy

Development of a communication strategy is an essential component to the SCP. It is becoming an increasingly effective voice for its members, the Paramedics in Saskatchewan. An essential component of communicating effectively for a specific group is equally effective communication within the group and other related groups effected by the decision making process.

The SCP has had fairly relaxed communication process in place relying on practitioner interest through the website, word of mouth, etc. to share its message. The message has, in the past few years, become much more focused and will have a far greater impact on the practitioner and needs to be communicated in a timely and effect manner.

To that end, the Phase II working group came together at the end of the Phase II project with the following questions:

- Target groups: Who do we need to communicate with?
- Message: What do we want to say to the target groups?
- Communication tools: How should we communicate with the target groups?

The following points outline the process that the SCP intends to put in place.

Communication process:

- The information gathered throughout the project will be shared with SCP members and guests through regular updates to the SCP web site. Upon completion of the project a document will be developed outlining the process as a part of the communication process.

Target groups for communication: In order of contact priority

- **Practitioners**
  Registered EMR's, EMT's, EMTA's, Paramedics
- **Employers**
  SEMSA, SAFC, Industry, RHA's/northern clinics
- **Unions (Exec.)**
  HSAS, SGEU, CUPE, IAFF, SEIU
- **Health Professionals (SK)**
  PAC, SPFFA, Professional Regulatory Bodies, Military (DND) SAHO, Educational i.e. SIAST, SAIT
- **Public**

Message to Communicate (outlined below)

Recommendation of Steering Committee for Phase I Sector Partnership

New CME Proposed to All Practitioners

1. Point System – as required presently
    - Credits from Approved List – open to practitioners input, yet requires approval from College
    - Mandatory credits, non-mandatory credits
2. Patient Contact (#'s, types of calls)
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    - Modules to identify gaps in learning
    - Remediation through simulation
3. Role of Facilitator will continue to exist; however, it will be redefined if and when the proposed changes take place. For those without access to a facilitator, a system will be put in place to meet the needs of all practitioners in all areas, such as:
        - Industry
        - Northern clinics
        - Ambulance
        - Fire
        - Military
        - Rural
        - Urban

Legislation Update

- Third reading passed May 8th, 2007
- Waiting for royal assent (this transfers Bill 8 into the Paramedic Act)
- Proclamation required – date pending
- Regulations are already in place to make transition
- Proclamation will allow powers within the Act to access membership data to make communication much easier

Communication format - Key points

- Keep communiqué informal
- Short (2-3 paragraphs)
- 2 initiatives – legislation and CME/ Sector Partnership
- website info
- membership card
- communicate how often newsletters will go out
- announcement of town meetings to be held at a later date

Additional communication information to be included

- Send out full Paramedic Act

- Send out full Sector Partnership report
- Membership cards

Communication tools

- Email
- Mail – yearly licensure mail out to all members
- Q&A on website
- Telehealth
- AGM in fall
- SAHO may assist in communication to RHA CEO's
- Town hall meetings throughout province – will need to be set up to discover how needs will be met

Communication Timelines

- Practitioners contact upon project completion
    - Letter 2-4 paragraphs re:
        - Legislation passing
        - Royal Assent
        - Next Steps
        - Membership cards
- Employers/Unions
    - 2-3 days later
    - Letter 2-3 paragraphs
        - Info on legislation
- Health Professionals and the Public
    - Wait until all is official re: legislation and transition
    - Timeframe for Communications
        - newsletter 2-3 times per year
        - Website updated monthly

Next Steps

Define parameters of/ create process;

i. Credits- How many needed, What each course is worth;
ii. Patient Contact – driving force;
iii. Role of Facilitator.

Pilot Projects- occupational standards;

Enhance partnership with aboriginal groups and youth through job fairs, high school counselors;

Explore recruitment and retention opportunities;

Break down CME into bite-sized chunks;

Target groups who are not affiliated with ambulance; and

Create a model for communication.

Future Considerations

Development of modules in future projects

- Whether to use an already developed program;
- Develop on our own - any program would need Canadian content and would need to stay current;
- Would develop a few modules at a time;
- Would need to be hired out;
- Would need to be piloted out to see if features are working.

Final Report

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- Would develop a few modules at a time;
- Would need to be hired out;
- Would need to be piloted out to see if features are working.

Steering Committee

The Steering Committee was comprised of individuals from all areas of the health care sector. The participants listed below either actively participated on the Steering Committee or asked to be kept updated and receive project information.

Dale	Backlin	Saskatchewan College of Paramedics
Derek	Dagenais	Saskatchewan College of Paramedics
Charles	Eddy	Sun Country Regional Health Authority
Karen	Eisler	Saskatchewan Registered Nurses Association
Terry	Klassen	Cypress Regional Health Authority
Brenda	Fry	Saskatchewan College of Paramedics
Gladys	Hill	AEE /Institutions Branch
Iris	Penner	Advanced Education and Employment / Programs Branch
Cliff	Orriss	Prairie North Regional Health Authority
Kyle	Sereda	Spiritwood Ambulance Care Ltd.
Ron	Dufresne	Moose Jaw EMS
Tim	Hillier	M.D. Ambulance Care
Ken	Luciak	Regina Qu'Appelle Health Region - EMS
Krista	Koenders	Heartland Health Region
Wayne	Nogier	Kelsey Trail Health Region
Duane	Fleming	SIAST
Brent	Stewart	SIAST
Dr. M.	Vogel	SMA
Derek	Keller	Sunrise Health Region
Bruce	Siemens	Saskatoon Professional Fire Fighters Association Local 80, IAFF
Rob	Hogan	Saskatoon Professional Fire Fighters Association Local 80, IAFF
Les	Karpluk	Prince Albert Fire Department
Dan	Paulson	Saskatoon Fire and Protective Services

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This report was prepared for the

Saskatchewan College of Paramedics Sector Partnership Steering Committee

By

Mercury Information Services

Linda Thauberger
Principal

Disclaimer: The Steering Committee recognizes there are some statements contained in this report that may not accurately reflect the Emergency Medical Services industry in Saskatchewan. If there are questions regarding the content of this report, the Saskatchewan College of Paramedics Sector Partnership Steering Committee is available to provide information and assistance.

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1 Focus Group Methodology

The Saskatchewan College of Paramedics (SCP), formerly the Saskatchewan Paramedic Association (SPA), has entered into Phase II of the Sector Partnerships project with SaskLearning and SaskHealth. Phase I was a broad-based project that identified general industry issues in Saskatchewan. Phase II will address specific issues identified in Phase I, particularly Continuing Medical Education (CME).

As a part of the Phase II process, a working group of industry members has been brought together to develop a new 'draft' framework for CME in Saskatchewan. To assist this group with their task, a literature review was completed to provide an overview of Continuing Medical Education models and practices at provincial, national and international levels, as well as interdisciplinary levels. The literature review is attached as an appendix to this report.

Continuing Medical Education is mandatory in Saskatchewan. However, the content is at the discretion of the employer/trainer/facilitator. The SCP believes that it will become a self-regulating body in 2007. The CME model should be in place when that becomes a reality. This project will take the current framework, expand and enhance it so that it can be put into place when the anticipated legislation comes into effect.

Practitioners' input was imperative for this draft framework to be most effective. To that end, ten Focus Groups were held (five with employees and five with employers) throughout the province in November and December of 2006. There were 34 participants in total, 12 employers and 22 employees. The focus groups were held in both rural and urban settings including Saskatoon, North Battleford, Swift Current, Weyburn, and Regina. We are grateful for the special effort made by many of the participants who traveled from surrounding areas in adverse weather conditions in order to participate. In all, the following communities were represented:

Saskatoon	Swift Current
Colonsay	Beechy
Biggar	Weyburn
Dundern	Creelman
Spiritwood	Lampman
St. Walberg	Gravelburg
North Battleford	Regina
Cut Knife	McLean
Maidstone	Canora

Participants for the Employer/Management groups were recruited for the focus groups from the database of service providers, industry representatives, and training providers. Employers were asked to post the focus group information to allow employees who did not complete the survey to take part in the process. Employee participants were contacted by SaskHealth directly because of privacy legislation. SaskHealth, as a partner in this project, sent out a letter to all licensed practitioners in July 2006. This served two

purposes: privacy was protected, and; the College had an opportunity to invite practitioners to participate in this project. A consent form attached to the letter asked for contact information. Practitioners who filled out the consent form and return it to SCP were included in the database of potential participants. A professional recruiter was subcontracted by the project consultant to contact potential participants regarding the logistics of the focus groups. The process was voluntary at all times; employees were given an honorarium to compensate them for their time.

It was pointed out by a participant that the groups titled as 'Employer' were really owners, employers, management, and training providers. The 'Employee' group contained practitioner employees and those who were also representing training providers. We acknowledge that the groups were comprised of more than employers and employees; for ease of reporting, those will be the titles referred to herein.

During the recruiting process, efforts were made to ensure that the groups were representative of the industry in Saskatchewan. The Employer/Management and Employee groups included:

- Urban and rural representation at both employee and management levels;
- Public, private and military services at employee and management levels;
- Training provider representation at employee and management levels;
- Industry representation at an employee level;
- Representation from Fire at employee and management levels.

Information from the focus groups will be summarized and presented to the sector working group to assist in their work on the proposed CME model. A substantial amount of data was collected during the process. In order to make this stage manageable, the information from all groups has been compiled. That is, all Employer group responses were reported together and all Employee group responses were reported together. The two reports were then compiled into one comprehensive document.

We would like to acknowledge that the information presented in the following pages is the opinion of the participants and may or may not be factual in content. It should be read as such.

1.1 Employee Focus Group Overview

1.1.1 Minimum number of patient care contacts

Participants were asked if, in their opinion, patient contacts should be tracked as a part of licensure. Participants had a fairly strong negative reaction to the suggestion, particularly those from the rural settings. Most were very concerned that they would not be able to attain enough calls or contacts to maintain their license. One participant indicated that it was understood that you could see from tracking what areas needed

attention but that Con Ed was in place to help those individuals keep up their skills in any given area.

> *"Speaking rurally, no. Cause you don't always get a vast array of calls. Like you can go for three or four months without ever having to deal with a trauma."*
>
> *"First, I think as long as you're keeping up to date with your skills and that, no, that can't really be considered because we average four a month, one a week is our runs."*
>
> *"Well, I think it is important for people out in the rural communities who do not see a lot of call volume, that this isn't tied to their licensing as far as contacts because they may not get an opportunity to have five or ten particular patients that they have to do their assessments on and so forth."*
>
> *"Because in small places by the time you get a chance to hit one of those, you may have very little patient contact. And I don't know what their minimum is going to be. But it needs to be a minimum or we're gonna lose people."*
>
> *"That's why there's continuing education. For example, if you don't have enough cardiac calls, then every two years you do a refresher course on cardiac. And same thing with respiratory... You do refreshers on respiratory. If its asthma, COPD, and you have to maybe branch it out and be specific, then I think it's necessary. But I don't believe you should track calls."*
>
> *"We run an ambulance but it's not an ambulance. It's sort of a grey area for the detachment. But for us to have to maintain a certain number of call volumes to maintain licensure, I would lose all those as well. Same as you."*
>
> *"And that opens up another can of worms where there are some services which are strictly volunteer and when the call comes in they respond on that call and they get paid for that time. And there are other services who have an ambulance that's on stand by whereas they could be going into the hospital on their shift."*
>
> *"Here's another thing too, is with the rural, you know, when you make the comment about if you don't have enough of those types of calls do you move to a busier service? Well, how do you go into a busier service if all the other services in that general area are kind of, well, have the same call volume? Then you'd literally have to pick up a family, and move a family somewhere in Saskatchewan to get them into a busier service."*
>
> *"You've got too many services that rely on volunteers or people that are paid just to be on call. The only time they're working is if there is a call. And you can't expect that person to say, come from Hudson Bay to Regina, because Regina's busier, and stay here for a month. Well, they've got their family and everything else going on where they are."*
>
> *"I just know that as a healthcare professional we're Class A personalities, and we want to do well. And things we're not well at, we better ourselves at it, or you won't be in this industry very long. So I think it would be a total waste of time."*

As well as those in the rural settings, those who were licensed as non-Ambulance personnel were concerned that they would not attain enough contacts to maintain license.

"No. I would disagree that you would have to have that. The primary focus is fire fighting. Their secondary duties are medical calls and they're not licensed as ambulance personnel. There's a two-tier system already in effect where you license as an ambulance personnel or a non-ambulance personnel. We're licensed as non-ambulance personnel."

Some participants agreed that tracking was a good idea but focused on the learning aspect of the exercise. One individual thought that each practitioner could track their own calls for information only. Some thought that if enough contacts were not attained in the field, that practitioners could access local hospitals for patient contacts.

"I don't see a problem in tracking them. It depends on what you intend to do with them, and how it will impact your license. I can understand what you guys are saying. I think anytime you have the opportunity to collect information, that's a good thing. It could be used down the road for a variety of different reasons. That's why I wanted to ask the question again. I want to know that it's necessarily impacting directly on your ability to work or not to have a service in your area, in your region."

"It depends on what you plan to do with it. If it's to set out a bare minimum to base your licensure, I don't know. If it's to collect data so that… you can determine maybe what your Con Ed requirements would be. Your Con Ed requirements might be based upon call volume and the types of calls and maybe you need to do more Con Ed versus someone who is doing a variety of different trips of different avenues that have on-the-street learning."

"I agree with actually what everybody's been saying, but there is value in patient contacts, in applying what you've got. So I can see where tracking the calls is a good idea, keeping an eye on what people are doing so they can get more intensive training. I want to get into a major centre and do some more of this and do some more of that. Leave the option open for them."

"If there is a hospital it could be possible for some of these people to go into the hospital and maintain patient contact that way. Even though they're not transporting with an ambulance or a First Responder that way, they can still go into the hospital and get their patient contact that way."

"Couldn't there be a way you could track it yourself? Like personally, I suppose you could track it in a non-formal way. Just so you know. Cause everybody knows their weak spots and their strengths."

Participants did not have any comments on how many contacts should be required because they were, for the most part, not in favour of the suggestion.

"I think you don't get enough. Someone like us – if you turn around and say you have to have 12 a year, we've only got three EMTs, you might wipe out all three EMTs and there goes your service."

"Well, for our setting I guess it would not be a problem, but I guess my question is as far as the tracking goes, who is going to be responsible for that? And if you're asking us to track that I can tell you that it's going to be difficult because of the amount of people we have to keep track of."

"A lot of times what it's used for now, too, and I mean depending on what SLAST is doing, specifically at this moment. We used to track it specifically for education purposes. In order to get into an advanced program or to broaden your career scope, you would have to have at least two years experience or 200 calls under your belt. So that's kind of the main reason why we were always tracking it. And as a service to see obviously how many traumas we do in a year, how many, you know, all that kind of stuff."

Participants were asked if the quality of calls or the quantity was more important when tracking and if they felt that some contacts should be mandatory. Most felt that the quality was more important because of the lack of regularity in some calls but all felt that if this requirement were mandatory it would cause problems.

"Because we do not get a lot of different calls. A lot of ours are all medical and we don't get a lot of trauma."

"If it's used to determine competencies, it shouldn't be the only method to determine that competency."

"See, that's another thing that's not gonna happen for rural Saskatchewan. When we do EMS we do it on the sidelines. We can't afford to take off and go to Swift Current for a week or to Saskatoon or Regina or whatever to get those. We're just going to go by the wayside and so is rural health. I guess the other statement that you were talking about is BC. I've got one person on my crew that comes from Alberta. And they were credited with their trips. It wasn't their sole thing but they were given credit for their trips."

"I would go with it as well as long as it wasn't a mandatory."

"If you make anything mandatory, then you have to flip it and say what if… So you can't just say something is mandatory unless you've got all the what ifs explained."

"For example, when you get young people starting, and they get maternity leave… then you run into these two year programs or five year or whatever your education timeframe is… and if it happens they have two kids in that timeframe and they are apt to let their license go and slide, how do you get it back?"

"I think it would be nice to see credits. I mean if you take a cardiac I think you should get credits for that experience. Or a major trauma, and go against your crediting, however they're going to make their credits. But I don't think it can all be one patient contact."

"I know I've had students who have come to Swift Current and it's taken a while for them to get the credits for the things they have to have. So I'm not putting that against the guy, but if my students aren't even getting it, Swift Current's not even getting it."

1.1.2 Written evaluation of skill sets

It has been suggested that a 'before and after' quiz be administered to learners to assess, not grade, the level of understanding the learner may have of any given Continuing Medical Education (CME) topic. Participants were asked if they thought this would be a useful way to assess the learner's knowledge before and after a CME session. Participants were fairly evenly split in their responses. Some thought it was a bad idea, indicating that they went to school already and did not feel the need to repeat the

process on a regular basis. Some indicated that a fear of exams and testing would put undue pressure on some participants. Some felt that a course evaluation might be a more practical way to ascertain the level of learning that any practitioner may have.

> *"I know quite a few people that just do terrible on tests. They will go anywhere, work anywhere, do a good job but yet when they get to a test, they can't do it."*
>
> *"I agree with what you are saying but I think it would make even more sense if you get into the exam before you taught me something and I passed the exam, [then] why are you going to teach it?"*
>
> *"I'm not saying the three hours of instruction would not be worthwhile but for me my time is valuable and I do stuff other than work on the ambulance and for me to give up three hours to be taught something I know if I passed it, if I aced the exam… I'm not saying if I got 80% on it… if I got 100% on it, what's the purpose of my being there for another three hours?"*
>
> *"That's like writing a test, okay. There's lots of our EMRs that just freeze at the thought. Whereas if it was a verbal test, it would be much better."*
>
> *"I went to school for a year and a half to get my ACP and to me, testing, I just don't believe in it. I truly don't. As I said, I went to school to learn how to do it. Will I show up at my Con Ed days? Yeah, I will, and take in my lectures and stuff like that, but I don't believe in getting tested in all of them before and after. It puts more pressure on people."*
>
> *"My answer's 'No,' because it puts too much pressure on the person not to learn but to try to memorize and think of buzz words and think of, "How am I going to answer if they ask this?" instead of relaxing and allowing themselves to absorb the material. Because as soon as you know there's a test, they approach everything differently."*
>
> *"You put a sheet of paper in front of somebody and you can just see the fear and just the freeze. And especially my EMRs. I mean EMTs and EMT-As have gone through training. Yeah they've been through exams. But EMRs are basic.... And if we lose them because we're scaring them of…"*
>
> *"I think people are gonna be more frustrated with having to write an exam at the beginning of the course and at the end of the course. If you want to evaluate an instructor, give them a sheet to fill in at the end saying, "Yup, I leaned something, no, I didn't learn something. Yeah, I thought the facilities were great, it lacked videos, or I didn't feel that the instructor brought the material forth appropriately." Things like that rather than having an exam."*

One service in particular posed an interesting question: Should the 'test' be specific to designation?

> *"I guess my comment on that is because in my service I have a paramedic, I have EMT-As, I have EMTs, and I have EMRs, I have RNs and I have LPN's. And I guess what I'm wondering is what these exams are gonna look like and who's gonna mark it?"*

Some practitioners thought it was a good idea indicating that it would give them a regular opportunity to identify areas that may need more attention. Some also indicated that it could be used in their favour at the time of their job evaluation.

"I think it's a good idea. We have to do our Con Ed regardless to keep our license outright so what's the harm in doing a test that can maybe make us, like… If we don't get 100% or whatever, and we thought that we knew it well… I thought I had my medical stuff aced and all I got was 80%… Oh! I guess I need to brush up and maybe that would encourage me to… put that extra effort during that Con Ed session so that when that end test came I got a good one."

"I agree. I think a continuing evaluation right from the time you have your in-services where you are practicing, let's say, CPR on the move, the facilitator or instructor can be watching that individual and if they are constantly making the same mistake then they have to be brought off to the side and say, "Okay, here's the new guidelines." And then have to revisit that issue down the road during the program. Kind of like what SIAST does with the PCP program."

"It would fall back to your job evaluation again, an evaluation once a year on your performance and your skills. If you're up to par where you're supposed to be, basically your Con Ed is to refresh your skills, not to relearn, unless you forgot. But generally you go over it just to refresh your skills, especially the ones you don't practice that often."

"I think it would be good, because if you've ever seen Con Ed in a small service like ours, half the people walk out of here not even knowing what they've just learned. So if you wrote the test before, and then wrote the same one afterwards, at least that would make people pay attention."

"So, if you write this before-and-after test, the after test I assume would be a pass or fail or something like that? I kind of think it's a good idea. You can see how effective the class is going to be. You can see the before and after, and see if they are absorbing anything."

Participants were asked: If modules were provided to read through on their own time that included a quiz at the end, would they find this to be an acceptable way of monitoring the CME process? The answers were fairly evenly split. Some thought it was a great idea because they would have a better idea of what they were learning, and some thought it was not feasible. They indicated that practitioners would be more likely to participate if it was a group activity rather than on their own.

"I would agree with that. I've just been through a process where we've taken module after module after module and each test process was 5 questions per module and the test questions were written in such a way that you had to know how the exact sentence in the middle of the paragraph in the middle of the page went in order to get the answer correct."

"…A lot of people that I know will not read that if you give it to them. But if you go through it with them, everything's fine."

Participants were asked what other methods might be used to benchmark the learner's knowledge. There were several opinions offered, most centered on verbal interaction, and group activity and support.

"Just verbally asking questions."

"We're legally obligated to the fire hall after teaching and we go through our practical stuff, and we do scenarios and stuff. That's where you can tell where book learning [has] been absorbed in the guy …"

"Ongoing evaluation through the whole process. The instructor teaches you how to, like for as an example, intubate. Well, the instructor's watching you intubate, watches you several times, and sees a progression. At first you're clumsy, knocking teeth, the whole bit. By the end of the day, you're just BANG in there. Well, there's been definite progression."

"I'm gonna say please don't go to where the fire service has gone and that is all… Half of it is theory and half of it is practical. And you can get 80s in practical and you can get 65 in your theory and you don't make it. And I've met … our deputy chief is an excellent fire fighter and he flunked almost every theory. And he is a super fire fighter."

"But as far as evaluating the person in the classroom, you can evaluate what they do on the dummy, but you get out on the real field, it's a little, the stress level is a little different, your adrenaline's quite a bit higher in the field. Are you gonna do the same job in the field that you did in the classroom?"

"The ones when I just do theory, I'll go back over them again at the end. Yeah we'll go through the boring blab blab blab, and then you go back and say, "Okay, so the eye does what? And what's the one thing you really want to know about eyes?" Or whatever. And then you give a bit of a verbal…"

"Our medical director's actually done a couple shifts where she's gone from call to call and she's just watched."

"What I'm doing if I can relate to the fire service bit, is there are strict exams that I'm supposed to be giving the guys and the gals and they're supposed to be writing it. I do what's called the study guide review exam. And we do it around the table. And we start with that and each person gives an answer, and if they are 100% totally stumped, and don't know it, the people sitting on the sides of them are helping them. It's a group. We can talk it out."

1.1.3 Simulation

Participants were asked if, in their opinion, simulations (scenarios) were effective learning tools. The majority of participants thought it was a very effective way to learn, whether it is the scenarios that are conducted at each individual service or some of the high tech simulator equipment that has recently become available. Although some indicated that they had not had an opportunity to work with the higher end equipment, most thought it would offer an opportunity to show examples of situations that the practitioner may not come in contact with. Although mostly in favour, participants also pointed out that not all people learn the same so learning should be a blend of activities.

"They're the closest you can get to reality without having somebody actually hurt in front of you. And you can build upon the skills required to go through a simulation. You can take them in a classroom. You can say this is what we're going to learn today. You can build on their skill level. Then you can say, "Here's a simulation. We're going to put all those different levels of skills to work in this simulation." And you can actually grade that as you go through a simulation."

"I haven't worked with them (simulators)."

"I think it's the only way to do things because you might not see anything for two or three years."

"That's where real life is still the best possible we have. Kind of the same as immobilizing somebody on a nice clean, flat floor."

"They don't necessarily help the procedure you learn. The circumstances differ again between simulations versus the real event."

"It's an excellent way to do it, but one thing I found too is…like…for our town, we don't have time to do it a mock disaster. But Swift Current does one once every year or sometimes once every two years and as long as we know they're on they have no problem with us going down there and not even participating, just watching. And even that's a benefit."

"That seems to be the way of the future because it sounds like there's units going from city to city that have a lab inside for instance and you would go in and if it's a cardiac arrest situation if you're at the ELS provider level you're in charge of this particular code and you have to know your drug dosages, you have to know everything and you are the team leader so therefore - and this is realistic - inside as much as possible but they got mannequins that could tell you how air is being put inside them, how much drugs are being put into them. I think to some degree we use that already in some of our programs. Some of these dolls like the ones that are intubations and IV arms and that…"

"It's really nice because you actually, when you're checking for a pulse you actually feel a pulse, you can see whether they're breathing or not. They've got [some] now that they even throw up."

Some participants did not feel that simulations and scenarios were as effective as first-hand learning. They indicated that how an individual reacted in a 'controlled' environment might not accurately portray how the same individual would react in 'real' life. As well, most participants saw value in the simulation but for learning only, not as a testing tool.

"…Patients don't follow the book."

"Things like that, when it comes like to either a scenario or someone who's having a heart attack. And you can't see them panicking, you can't picture it properly. So I do think it makes you narrow-minded to a point, because they only describe so many… So I don't find scenarios to be overly helpful."

"But I don't think it should be used for testing purposes. Just for learning… I mean its okay, but I mean you've got the person that's hiring you, you've got your boss sitting across the table from you looking at you. You're dripping sweat. I've also seen people that can ace a scenario, and you get them out on the street and they might as well go home."

1.1.4 Approved credit list

Some jurisdictions have an approved credit list. Participants were asked who, in their opinion, should decide what credits are appropriate for the list. A number of participants indicated that the College should be involved, either as the primary member or as one of three. Practitioners also indicated that they would rather see peer

involvement in the process rather than someone who may be seen as an outsider. They also thought that all EMS services should have an opportunity to contribute to the credit list. The prevailing thought was that the 'learner' should be involved.

> *"You should be able to go to somebody. I am just not sure who. I guess probably the College. As far as the College goes I am okay with that as long as there is fair representation so that there is a member on that Board that can say that these particular topics are appropriate for that service so yes they should be there."*
>
> *"I think you should go back to the practicum sites and talk to EMS services because some may do more hip transfers or more let's say long bone fractures [or] whatever than another does. You have to talk to the clinical sites in hospital to see what goes through Weyburn General in a day compared to the Regina General in a day."*
>
> *"I think whoever is doing our accrediting, whether it's the College, whether it's SaskHealth, whoever ends up doing our accrediting should be the ones who take control of that. I agree it should be the College, but with unforeseen circumstances and knowing our government it could be anybody. So whoever is in charge of our accreditation should be in charge of that list."*
>
> *"I would imagine the committee would have to evaluate and set up some sort of standard."*
>
> *"The learner with the education committee says this is what our area does. I'm involved in a rural ambulance. Therefore we're in oil patch, we are a farming community, we have one swimming pool, we help on the fire department, we're often called to rural accidents, etc."*
>
> *"EMS workers, not some guy that's from Toronto, who doesn't know what he's doing."*
>
> *"It's coming from all of us. It's going through its phases sort of thing to get to the people that it has to get to. But if they're listening to what everybody has to say… I don't see a problem with that at all."*
>
> *"Well, anybody can send one in but have the committee to review it, I guess. Submit using an approved format for review…"*
>
> *"People that work in the service."*
>
> *"But I mean it wouldn't hurt for grassroots to come to you and say, "Geez, this is something I've always wondered about and we've kind of had it happen around us. Do you think you could give us something on whatever (topic)?""*
>
> *"Yes, but at least it's coming from practitioners… Like the Continuing Education we have in place has been the same since '87, and it hasn't changed a lick. The topics are all the same. It's up to each particular service if they want to do something different, and how in-depth. So you don't have any continuity. One service might really go in-depth on certain topics while another service just reads them."*

Participants were asked what criteria could be used to determine acceptance. Most were unsure of the specifics but thought standardization was a good thing. Also, many participants thought it was good to have each service submit information that was specific to their services.

> *"If you can leave it as a bonafide requirement for your particular area, there should be a mechanism to bring it forward either at the annual convention or whatever the mechanism would be and have it voted on by possibly the membership there."*

"If you can approach the subcommittee with something your service needs, and get something accredited, I think you should be able to do that at any time."

"But that each service really knows what they have to focus on, like each separate service."

"And I guess one thing I'm thinking about is Swift Current goes out to the rural area, definitely. But what are their chances of getting a farm accident compared to us in very rural Saskatchewan? There's nothing on "How do you turn off a tractor?" Do you know what you can't touch on there that's gonna make it squeeze harder or blow up in your face?"

"I think that any time that a new demand or a question comes up from whatever sector it be that it would simply be a process of make the application to have information out there regarding that conundrum brought up. The committee is charged with going out and finding science-based information to provide back to you."

1.1.5 Facilitator model with shift towards practitioner ownership

Saskatchewan currently uses a facilitator model to track and monitor CME. Participants were asked if, in their opinion, this was an effective method. Most participants were very happy and comfortable with the facilitator model. They felt that it gave them a definite advantage to have someone staying on top of their education and licensing requirements. Most indicated that they had enough on their plates to worry about. In the more rural areas, it was suggested that having a person dedicated to this function would provide a more direct lead to current learning opportunities.

"I like the fact that you (the facilitator) track it. I mean this year we did it all and then we did our refresher or whatever and then he said, "Anybody who gets a second email needs to come in for extra curricular…" I like that option because it kind of made us do it but it also kind of took the burden off us to take care of it. Being on call and stuff you work and you come home and you don't want to do any homework, you don't want to sit there. But if you have to come and get it done by the end of the year you get your refresher and everything's good, it's kind of easier on us."

"Well, speaking from Regina, it's great. That's her job. She's literally hired as our educator. So if that's what we're paying her to do, I believe that's what she should be doing, and she should be tracking to see what I've done, what Doug has done, what Carla's done, if you guys worked for us. That's her job. So she should know how many credits we need, how many we don't have, what we need to take. She plans our education days. But speaking for the rural I don't know."

"That's almost what it sounds like they're trying to do. If I took my training separate from my facilitator I can see the point of me looking after my own paperwork. But when he's sitting there with me, doing the same thing…"

"And see, that's again rural. You only have so many employees. What we have done is one night a month we do Con Ed. And sometimes it works, sometimes it doesn't. Depending on how busy the service is at that time, things like that. And one person is assigned all the paperwork and they look after making sure that everybody's got the credits and stuff like that."

"For the urban people, you're probably not going to see a difference. It would probably be more for the rural people who may have more opportunity to seek out learning opportunities."

"I think it is effective. That way then you know that each is getting sent in, and it's being tracked."

"The problem is now the personnel we have that are in charge of it gets sick, breaks his leg, changes jobs, there's nobody that can do it for us. Who's responsible for that? Us? Him? The company?"

"Facilitator is more of a co-coordinator where they have access to certain educational sites because the individual hasn't been working in EMS very much. And I'm thinking in the rural areas, they just haven't got time. They're running the family business or whatever… They just haven't got time to do that. But they can say, "Give me some places I can go to get this information." And they say, "Okay, here's a package. Here you go.""

"But at least this way we know where they're at. If there was no facilitator, you'd get to October and all of a sudden there'd be 40 people showing up. We're starting into a new 2 year season, and so I will go through this coming up year and the January of the next year and I will write everybody saying, "Hey! You've got a year, you've got this to do. Get with it.""

Some participants thought the facilitator model was acceptable, but it should be standardized and the role and responsibility clarified.

"This whole area is ambiguous because my idea of a facilitator… Many years ago through MD, and I don't know if you guys are still doing this, I actually took a course offered by MD to become a facilitator for the required components to be certified. They paid me fifty bucks and I had to go out to the rural areas, the fire departments where we had first responders, and I could facilitate the teaching of those critical modules so they could be licensed. I don't know if you still do that or not. When we wanted to get the facilitators within the fire department all we had to do was send four names of EMTs who were certified at the time into SaskHealth and say, "Okay, these are going to be our facilitators." And they are the individuals responsible, not necessarily for teaching everything, but for leading the learning process. That's a facilitator in my mind. You lead a learning process. You lead a group of people through a process to an expected outcome. That's facilitating. Along with that they also got the paperwork end of the deal. They are not just there to just to complete the paperwork. So we had certified facilitators approved by SaskHealth who could do this. Now my question is for these certified facilitators – any facilitator that I go to who is certified and has that credential I should be able to take anywhere in the province, get that ticked off on my card, and I've completed that learning process. As far as sending in that piece of paper, I don't need an individual specifically to send that piece of paper in. I can send that piece of paper in myself. But the way it is now the facilitator signs the bottom saying that all of these critical modules have been done and they're initialed off by whoever did the instruction. So that component is done… We have different ideas about what the facilitator is here, so the answers are very wide open."

One or two participants were blatantly honest and said they could not be bothered to keep track themselves and would likely work somewhere else if it were not facilitator based.

> *"…If it was practitioner based, the ones that aren't motivated to stay in the industry, I don't think they would. I think they'd say, well, do I go out and work in the oil patch and make $26.00 an hour or do I stay with this EMS service and, what, I maybe made $30.00 last month, working a couple calls or something like that. No, I'll go work in the oil patch, because it is money-driven…"*

Some thought it should be more practitioner-based but this was not the predominant thought. They felt that they have first-hand understanding of areas that require attention.

> *"It would put the onus more on the practitioner, because that's what I find a lot of the time is you've got people that kind of sit back and don't go out and look for which access. Personally, I think we talked about it before. I know my weaknesses and I know what I have to work on, so for the next (while) I know what I have focus on. And I go out and get it. I think that it's nicer for the facilitator to schedule your Con Ed for you because you don't have to go out and do it yourself. But I see her point, you can practice what you need to practice, and see that you do it yourself."*

Participants were asked what other methods would be equally or more effective. Some participants indicated support for the Alberta model.

> *"As far as I know, [Alberta practitioners] get a scenario on their sheet or whatever the case may be, and they'll have to go through that. Each individual person has to go through that. In a lot of ways that's a very good thing, because it keeps the person interested, it keeps the person interested in doing things on their own, it makes them look at their books and it makes them study."*

1.1.6 Modules for CME

Some CME credits have been developed in a modular system. Participants were asked what, in their opinion, would be the best way to deliver these modules. Examples given were DVD, Telehealth, and Internet. Participants were happy with all methods of delivery, indicating that for different situations different methods were more appropriate. Participants did indicate that they supported Telehealth but very few had accessed it recently. They also indicated that the tapes currently supplied were badly in need of an update.

> *"The Internet would be fine and the DVD would be fine too. We have access to virtually all."*

> *"I have to say that Telehealth is different from what you're used to. Telehealth being what we have now is live interactive."*

> *"Telehealth would be nice…"*

"Telehealth has a problem because if we went e-solution over the Internet, we got to where there was still dial up. You're going to go back to that old snap, crackle, pop, pixilation."

"A combination. Can't pick one. There's a vast variety of ways of spreading information that you can't really pick one thing. DVD's the best. Telehealth you have to have options. …The chances of us getting Telehealth for a community of 10 that meets once a month isn't good, but at the same time if that same thing is optioned on DVD, throw it in."

"We use CD-ROM in our BTLS training. In the back of one of our textbooks is a CD where you can take it home and there's a games module back there that you can play games to learn the terminology, to better understand what a term means when you come to class. That's quite helpful for some people. But again, people have to have access to a computer and feel comfortable with it."

"I used to have people who really used to like the SaskHealth tapes. I mean, I know they weren't really great, but if they missed something, they felt better because at least they were learning something. They could take it home and learn something. So they liked that sort of thing that they could take home. I know I've had a couple people go online with MD and do their online education and have liked that. There are a lot of Con Ed options out on the Internet."

"And the DVDs, getting back to that, a lot of people really are interested in the DVD factor. They have to be current, or the videos have to be current. If I come back with something from SaskHealth that's from 1970, everybody's bored. They're making more fun of the clothing and the hairdos than anything. And they're not getting anything out of it anyways."

"We're learning in health care that we are expecting too much too soon because it's a whole generation that's still not really familiar and comfortable with computers."

"A live broadcast would be better."

"I think one thing that would be neat for DVD for the rural is if you guys were to get together one night a month to do it. You all sit down, you all watch it and you could all discuss it too. And have like a focus group and a forum and discuss it."

"Most formats, we've all seen terrible videos or DVDs, and you know it is a waste of time. So it's down to just the quality."

"A lot of time it's nice to, even if you could share, it's easier if you have somebody come in from outside rather than the same group of people that's always there."

Some participants thought that SCP should develop a page in their website where practitioners could access learning tools.

"I'd also like to go a step further and say what the College could do is, for instance, spinal immobilization. We take that as part of our two-year package. So, maybe the College should have 10 lesson plans available online. So we can go and take a look at it. …And have them different lengths, two of each level or whatever they want to do, and you can go in and select the one that fits with your people and use that. And then you have an accredited lesson plan at least. Once again, you are still going back to how well it is instructed. But at least you got a lesson plan you can follow."

"I think that's where something needs to be set up within SPA. Okay, let's say there is a website that we can access thru SPA. Everybody can go on to that, everybody accesses the same information as opposed to one person going to this website and another person going to this website, or ten different things and everybody's learning something different."

1.1.7 Inter agency sharing of Continuing Medical Education information

It has been suggested that CME information be centrally stored and accessed by the learner or educator depending on need. Participants were asked if they thought this would be an effective way to ensure that information is available to all, regardless of location. Participants like the idea of central information, but were unsure if it would be physically or virtually stored. They were in favour of a virtual library with a SCP person coordinating it. Some rural participants were less happy with the thought of a physical library because of the travel or delivery time involved to access information.

"So if you just phoned the library and said I need three DVDs on A, B, and C, you could just order them up and they would be there in three days."

"Everything has to be based on the committee because you are going to have such an influx of information. It will be a mess."

"The only problem with that is that, "Oh good, if it's a physical library, wonderful. I'll phone." Well then, what happens if it just gets up and running and you do a virtual and, you know, just log in, use your password and you have access to the whole library."

"I'd have to say yeah. Okay, say that they put a link on the website. I can go to it at 3:00 in the morning because I had a call about something and, you know, go back and look it up and maybe read a little more about it."

"Absolutely"

"I would like to download the information on head injuries, recent head injuries, and it's all pertaining to their Saskatchewan protocols so it's not a tape we got from the States, brought up here, and it doesn't apply to us. We have to have current information that applies only to our protocols. And that's where that facilitator could say, "Okay, if you don't have a computer at home, I'll download this for you. I'll print it off, and here you go.""

"Depends if we have to travel too far. Like, I don't want to have to travel to Regina to do it. Whereas if I could do it in Lloydminster or North Battleford, closer centers would be good."

"It might work in some ways. If there was a certain thing that you needed or that you wanted to work on, that you were weak on and you wanted to… you could access."

"That's along the lines of, if this comes down to a computer-based process, I don't know about anybody else, but after writing an exam I like to know what I got wrong, where I did good, where I did bad. Like I could say, "Okay, on pharmacology I got 6 out of 10. Well, where did I go wrong? I need to know where I went wrong, why I went wrong. Did I not understand the material properly? Or I get 10 out of 10, okay."

1.1.8 Transparent layout of requirements

Participants were asked what type of information they would like to receive regarding CME requirements. Most participants, surprisingly, did not have much of an opinion on this issue. They indicated that the facilitator looked after it all so they did not really pay attention to it. As well, some indicated that the letter and requirements had not changed for several years so it was not an issue.

> *"I don't even think it goes to the facilitator, because it hasn't changed for 20 years."*

> *"Basically you just go. The facilitator teaches you what they want to teach you. You don't know how many credits you have 'till the end… Most of the time, you're way over the top."*

1.1.9 Other issues and comments

Other issues were raised at the time of the focus group that may warrant review but do not necessarily fit into a specific topic area. Those comments are listed below in no specific order.

> *"I guess I kind of touched on it. It's just that I have that large range of people. And when I hold one Con Ed session I don't want to hold 4 for every level. …I gear it to maybe a little higher than EMR but it's definitely lower than EMTA level. And I feel I've been cheating both of them. And I know as a facilitator there's only a certain height that I'll go to that I feel comfortable. I mean, I have my RN, but I do not feel comfortable teaching my Paramedic. He's got things that are way above me. And I don't think I can teach him. He should be taught by a doctor. Well, our doctor is gung ho to come in and teach but he's away a lot. Who am I to say you're right or you're wrong if it's me that's setting up the education and the questions…"*

> *"I think, you know, that sort of sums up the whole Con Ed issue in that you need diverse solutions. Because, we've said there's all different kinds of learners, there's all different kinds of workers, there's all different kinds of geography, there's all different kinds of services, there's all different kinds of org charts… like ladders, who's who, preceptors, employers, practitioners. There's so much… The whole industry is very diverse and so needs the education to be that way to meet the needs of those out there."*

1.2 Employer Focus Group Overview

1.2.1 Minimum number of patient care contacts

Participants were asked to indicate if they thought that patient contacts should be tracked as a part of licensure. While most saw the advantage in the activity almost all of the participants were quick to point out the areas where this may cause difficulty. These included the difference in call volumes between urban and rural and the issue of what to do if the requirements were not met. Some participants indicated that in a rural setting they were simply not in a position to refuse license if the requirements were not met because of the availability of qualified potential employees; this would not necessarily be the case in an urban setting.

"… I believe it's going to be very difficult in the diversity of the province, to be able to say that you're gonna have this many types of calls and input. I mean, depending on where you work, you may get multiple calls, whether it's going to be traumatic or cardiac…."

"…definitely that's going to be a challenge, especially like places like Whitewood. It would be a problem but at the same time we can't negate the fact that if they don't have the patient contacts then they're going to rust out."

"….some of those personnel may see one person a year. But we're not gonna let that employee go because of that, because it's a call volume issue. It's not the fact that they're not on call. And we need that person in backup situations."

Those that saw the advantage felt that it would be an excellent way to track varying levels of experience and some indicated that it would be an excellent extension to Con Ed in that they would be able to uncover specific areas that require attention in a rural setting and identify areas of expertise that may be used to the trainer's advantage i.e. in some services practitioners participate as educators during Con Ed sessions.

"Patient contacts? I think it's absolutely important. Whether to use that to say you're efficient at cardiac calls or you're efficient at trauma, I am a little skeptical to say that would be something to put so much weight on."

"I believe it should. And we actually just recently did something like this because we're having a lot of trouble with staff who are working casually for us, and then work in other places like the Police Dept. and so on. And they come in to do a few hours and then they're gone again. And we're really concerned, especially at the ACP level. WE feel that they do not possess the amount of patient contact necessary to keep their skills up. If it was a quiet day and they really had minimal patient contact, and normally we don't have many of those, but there's always that possibility."

"I think there's too much of a complexity to try and baseline, you're going to have to have… I mean, in order for you to re-certify you're gonna have to have 145 calls a year."

"In a volunteer service, I have a tiered group. I have 2 or 3 that are EMTs, all the rest are EMRs… so if I understand what we're talking about here, I could have ½ of my people that couldn't be licensed, because they don't hardly make a call. I've had somebody that's been on 5 years (?) that's never made a call. And if they do go, they're just going to drive. Is that what we're looking at here?"

"That could be a really good teaching aide actually, because not only could you see where people maybe need further recertification or some brushing up on issues but you could also track the ones that, "You know what? You've had a lot of experience with that, would you mind doing the instructing on that particular module."

"Put this in a CME perspective. For CME perspective, I think if a person did a number of calls, cardiac calls for instance, and the number of procedures based with those cardiac calls, from a CME perspective they may not have to do the medical component of that education. But it should be assessed. Like their treatment should be assessed for those calls. If for instance, how many IV's did they start in a year? Did they start at 1500 IV's, then certainly they wouldn't need medical direction, medical control to sign them off after two years."

"I think it's important to track calls, I think there's different skill sets that you use on different calls and I think those skill sets should be monitored. The numbers I don't think should be very much different between a rural or… so in other words if you intubate, the minimum requirements are two intubations a year, you should be able to do two patients here or two intubations in Saskatoon. If you can't then I think there should be other things set up through the hospital or they can go do or work and do two intubations."

One participant, a representative of Fire, felt that tracking would be a very useful tool. They indicated that many of the new potential hires that they have spoken to have their initial PCP certificate but do not have any Con Ed and therefore did not keep their license current. Tying patient contact to license may change this.

"In the fire department… a lot of these people go to school they get their PCP to get into fire departments. We're going through trouble right now, is a lot of guys are trying to get on with the fire department, and they didn't get Con Ed, they didn't keep their license, all they did was go to school. They got this little piece of paper and now they expect to get on here. But what they don't realize now is the fire departments are going in, because they do have programs where they work side-by-side with EMS. So they want you licensed. And these guys are scrambling, because they never kept up their PCP, never did any Con Ed, never did nothing. So at that aspect I think it would be important to keep track of those guys to keep their licensing. But if you're already working for one of the services I don't think it would be necessary because you are getting the exposure you need."

Some of those that were in favor of tracking thought that it was something that the college should institute and oversee.

"We could make that a benchmark that we all follow, but I would rather it came from the College. That would be better because I think we have a really good team, we all work well together, but there might be other regions out there that don't even talk. So benchmarks may not be set by those regions and that means that there's going to be parts of Saskatchewan. that wont' have that kind of benchmark used. So I think it needs to be set by the College."

Participants we asked if they thought the number of contacts should be tracked and what the 'right' number should be. Most felt that it would vary from service to service.

"… to tie it in numerically isn't as important as to tie it in qualitatively in terms of when they do have patient contact. How well did they do in assessment, how well did they do the procedures. And that basically has to be something that you have to have confidence in their in services that they're doing a good job at the basic levels."

"I don't know. I think that number would be varied depending on urban and rural."

"…we're not disagreeing, we're all saying patient contacts should be the benchmark, it's just what happens if the # of patient contacts aren't there. There's the option of sending them to a bigger centre, which I think none of us particularly like."

"Well obviously rural providers don't do the number of calls that urban providers do, so if you had a standard five combi-tube insertions, rural probably wouldn't be able to meet that. So in that instance they would have medical control/ medical director sign them off."

"I can't remember exactly what it was my manager decided on but I think it was 15 patient contacts at least every three months."

"I see it being a problem because in our service we have EMRs as well as EMTs. And I have a number of casuals who only work maybe 3 or 4 times a year. So if there's a minimum, then how am I going to be able to get them to get their minimums? That would be my problem because for us if there's an EMR and an EMT working of course the EMT is doing the call. So and then unless we have just a simple transfer where the patient's very stable we encourage our EMRs to attend just to get those skills."

Participants were asked if contacts should be mandatory and what type of contact should be required (quality vs. quantity).

"Knowing how to deal with your patient, getting them out of the situation and getting them into your office which is the back of your unit, being able to converse with that patient and find out about what was going on was more important than knowing how to do a certain type of call."

"...this idea of the rural services coming through and doing tours in Regina or bigger services, that causes a big problem for us rural services because we don't have the staff. So if I'm sending my staff into Regina or Moose Jaw (because we're closer to Moose Jaw), to do term, to do ride outs or whatever, then I'm losing my staff."

"Just because a medic has a patient contact with cardiac instances 20 times a year doesn't mean that he did a good job."

"I guess my biggest concern with any patient contact, I have various very small call volume ambulance services and if patient contact was one of the mandatory, there's a considerable cost that I would incur sending those people to another site, and I would actually lose many of my staff if they had to go to another site to do it, because most of them are on-call casual. They started in as volunteers they have now evolved into casual employees against their will. But I would lose staff over a mandatory requirement."

"I can see it as an optional. Because just from two experiences I've had in the last week where I just happened to be in two of our smaller sites and they got calls and I went along with them and... the level of care is not what we need it to be. When you're doing six calls a year in one site, it's pretty tough when the staff might not do a call for three years.

1.2.2 Written evaluation of skill sets

Participants were asked if, in their opinion, a 'before and after' quiz would be a useful way to assess the learner's knowledge of a CME session. The quiz would be administered to learners to assess, not grade, the level of understanding the learner may have of any given Continuing Medical Education (CME) topic. Participants were not really in favor of this option although they saw the benefits. Most were opposed to testing of any kind indicating that it just upset people regardless of the fact that they were not being graded. Some indicated that it would add to a workload that was already heavy and some simply did not see the value.

"All you're doing is creating more paperwork for everybody and whether it gets looked at can't be said, you know? And is it, are the reports viable? That could be just that one

person's opinion or not. But I find the more paperwork you create the less results you're probably going to get."

"I suppose why not, I mean, what have you got to lose? But everybody learns something at every session, give them the before test in two weeks to see how much they've retained. It's easy to take a test right after you've learned. Of course you're going to learn, you're always learning, you're always refreshed."

"You're in volunteer mode and you have to be mindful of what your demands are too then, or else they will walk. We come from or we're in a little bit different mode, where we're paying salaries, they're being paid to be there, there have to be some expectations on both sides, and accountability."

"In some of our sites we are doing that currently just so we can customize our training a little bit more to their needs."

"Our guys will test, because they know they have to. And they have been traditionally tested in one way or another. It's a little harder with the fire department though because of the union issues. Union instances would be hard. But I'm wondering if this, because it's a test to check… you know, it's not like a pass or fail. But I wonder if you could get by with something like that."

"I'm not against testing and I never have been against testing, but I can sure see where that one could cause a lot of stress for people thinking, "Every time I go in to one of these sessions, and I've already passed this course once, I'm gonna be tested every time I go in now.""

"And you know, people are tired of doing tests. We're all intimidated by doing tests, but on the upswing, what you complete the test and you see that this isn't so scary, and you start to do well, it's a measurement too for yourself as well. I can do this!"

"So I think it's redundant. Of course you're going to learn something. I don't see any real benefit in taking an exam prior to a session, because it's not really important what the person knows at that time, it's what they know after."

"There's probably value in it… I think people would be a little hesitant to share what they knew or what they didn't know."

"I definitely agree that different people learn differently. And it's been a good example, like when you have people come through the hiring process, some people do horrible on exams, but you put them into a scenario and they do wonderfully. So for the Paramedics Association I can understand them wanting to do an exam after just to make sure that their standard is actually met."

Some of the participants indicated that they would be a little more supportive of the process if it were not their responsibility to administer or review the quiz. They indicated that sometimes those that were being tested felt that there might be bias on the part of the individuals that were reviewing the test answers. They felt that SaskHealth or the College could pick up that task.

"You can maybe have SaskHealth set up a form. They can send it out, the employee can fill it out, and send it back in. It doesn't have anything to do with the service…the employee may feel a lot better about it too. If they're struggling in one area or may not know anything

about it, they may do it more…whatever. But I find that the more paperwork you have to do, and it makes the employee a little more unsettled because they feel, like you say, even though you're not getting graded, you actually are… I wouldn't go with SaskHealth, I'd go with the College."

"If it was a practical exam that addressed skills and protocol and systems and approach, yeah."

"I had to pass my National Registry in the US. What happened is we had our pages and pages and pages of different sections that we had to pass, and you HAD to pass each section. And it was… It would have been neat if we had something similar to that. And you set it out from the College, but it's graded in anonymity and sent back to the individual, and then they look, "Whoa, do I suck at OB. I better bone up on that before I get into my Con Ed year." That would be a really good idea."

"I think the anonymity is really important too because this way it gives the paramedic an idea of what they're in for."

"The paperwork …there's too much of it as it is and…but there's that fear that if you do it in a group… Like we have 15-20 people that are Con Ed, in services and if you're handing out a test then it's… Everybody's leery of doing it. But if it comes from the licensing body, whoever it is, and they have to send it back to them, I think that would be a good idea."

Participants were asked if they thought that providing a module with a quiz component would be an acceptable way of monitoring the CME process. None were opposed but none were supportive of the idea.

"Yes, in part of the CME process. If the questions are graded in such a way that you'd have to read the module before you answered. I've heard of it before where they've put in trick questions at the end so that if you didn't read it you're not going to pass that quiz."

"My only thing would be as long as they can't get all their requirements from doing those, that there still needs to be a certain degree of practical work."

When asked, participants felt that actual in the field observation, by a superior or a peer, was the best way to assess what a person has learned. Others felt that working with the written material in a group or organized session enabled learning.

"Okay, the exam is one, and practical education. But you're not gonna know that unless you are in the back of the unit with them and watching what they're doing."

"Unless you do scenarios, and only then it's in a controlled situation, it's not the same thing as the field. I've seen people do wonderfully on scenarios, and absolutely freeze in the field."

"A lot of your learning is not in the book, it's not in the school, it's not in the classroom, it's when you get out there, and you see the situation. And the learning isn't the fact that you know everything you need to do, it's more of you get the confidence to use what you have. So I really don't now how to assess that. How can they assess that when people get out of school?"

"The best thing I ever did was to go around with other paramedics in the city. And they say, this is what works. It is amazing where it comes from. It's not going to be in the book, so that stays all within the group, and they can pass it along."

"We can go months of somebody operating poorly, until someone tells me, it won't go anywhere. Because I am the owner. It doesn't go past me. Some of them that are very conscientious of patient care they will say, you know, we've got an issue there but…"

"What we tried was call reviews after each call where the staff had to sit down and review the call what they liked, what they didn't like, what they'd do better next time. It was just a format… just a couple questions on a piece of paper, they didn't write anything down, it was just a peer review with each other – it was the team review is what we called it. And that worked well in a couple of the sites that had low call volume and they reviewed the protocol after and it was just left between the two of them."

"I know with the PCPs coming out what we do is we actually use the paramedic book that they use in school, and we go through the chapters and we pull out the information that they were taught so we're all on the same page and that's what we use during in services for Continuing Ed. And we do that and we compare it to the SaskHealth protocol manual, rather the continuing education manual, and that was written back in 1986. It's very old and hasn't been updated, and it would be great if this was put out because then we know, okay, this is what we have to focus on. This is what we need to do, rather than… because the PCP book, or the paramedic textbook is for a national base. And I'm all for people being accredited nationally, but knowing 15 different signs of a toxic gas inhalation (in rural Saskatchewan all they use is anhydrous ammonia) doesn't really help me much. I understand it needs to be there, but it would be great to know what we need to focus on, that would be wonderful."

1.2.3 Simulation

All of the participants felt that scenarios and simulators were effective learning tools. They indicated however that as with previous topics, all learners learn differently. Another area that most mentioned with simulators and other 'learning tools' was the cost involved; several felt that the cost was out of their reach.

"I think it's important to do simulations, sometimes, you know, just… to probably to see where people are at."

"Definitely scenarios, things like that; they definitely can be a good learning tool. Just depending on how they're used, how big a group you have. For somebody that's a hands-on learner, if they're not, you know, it all depends. And there's some skills that we do with our CME that you need hands-on. Like your spinal and different things like that. So definitely, yeah."

"It's the best way to learn."

"I know there's big pushes towards utilization of mannequin and computer-driven recertification. Is it financially viable for small outfits? I don't even think it's viable for large outfits."

"Well of course they can. If you have an actual simulator that you can perform your skills on or mannequins that can respond to the skill that you're administering, of course you're

going to see the effectiveness your skill is having on the mannequin, but to say that that could be a component of every operator's CME program, it's not realistic."

"Like I've got one EMR who's a school teacher. And sure, she comes up with the greatest scenarios, but to try and act them out so that when you're doing your patient assessment you can, you know, come up with it, it's tough for people to remember. So, I think some kind of program like that would be really good."

"Simulated for learning? Great. For testing? Not so great."

"I think in this whole process, when you're big and you have that, that's really great. But the thing is, we're in rural Saskatchewan, and you know what? We're far from some of those nice big sites. So how are we going to maintain services out there?"

"I've been in 15 years and I haven't even come close. And I think especially for rural, for IVs, to keep up the skills. Like, we're struggling with that right now. We're not EMTs as yet, but we're struggling with it because we've got 4 people… there's 4 of us that would like to take it, but we're going, "How the hell are we ever going to keep up our skills?" Because the amount of calls we do, and the calls that we do, we wouldn't' be able to use those skills. So to be able to keep them up so that when we did need them… without simulators, we're just not going to be able to do that, we're not going to be able to keep up our skills. And like, we work right out of the hospital so we have a good working relationship with the nursing staff, but they're going, "We don't want you to do IVs because we don't do them enough either. And so now you guys are going to come in and do the IVs and we're…" And they're struggling with their skills too."

One participant suggested a jointly purchased mobile simulator that could be budgeted for and utilized by all urban and rural service.

"From the readings that I've done sounds like it's a very effective tool. And I believe it's been pretty effective at our RQHD EMS, at least in Regina. The only problem is, you've got to maintain your simulation equipment, otherwise it becomes a hindrance. I just put in a request for $100,000 worth of simulation equipment and another $0.5 million for a bus so we can hit the road and go to Moosomin, all these places. Or if you were planning on going around to these small communities I wonder if it could be a big Saskatchewan thing that each little ambulance then put in money and then, for this truck to go around and do the thing instead of being the responsibility of one buying it."

"Simulation equipment is expensive. I'm looking at a doll right now that Saskatoon just bought for $52,000 and I want that doll."

"So again, I know I'm kind of speaking out of turn probably for a lot of my colleagues across the province, but I really do believe that it's the responsibility of the region to provide that equipment to the services because no one's going to be able to buy a $52,000 doll right now. Training heads. Easily they're over $1,000. All this equipment is expensive, but I believe in it. Like, I really do believe that the simulations are important and it's just that we've got to make a way of making it available to everybody."

Participants were asked to identify their learning expectations with simulations and scenarios. Most felt that learning depended on the learner but also most indicated that they felt that hands-on learning was a great tool to see how the learner really reacted in a certain scenario.

"It depends greatly on the learner, because some guys like me, I learn more from doing the hands-on scenario things. Jack over in the corner there, he learns better by actually listening to somebody speak about it and describe."

"Some people have to be left alone and let them read about it and they've got it figured out."

"You can do scenarios for simulations, it doesn't have to be an electronic one, and we rely on the scenarios on the floor, but does it show you that they're confident? They know how to do it in the classroom, but when they get into the field, can they apply the knowledge?"

"I think simulations are good, and I think to put them to a test how they would act, if they can do a situation very well, I think that there's a certain competency that they can perform."

"I guess just my experience, because I was a PCP instructor for SIAST for two years and I saw some really good students that came through the door that could just bang out a scenario but went to the field and they just froze and forgot everything they know. You sit in class and think, "I just can't stump these people, I cannot stump this one." They're that good. They knew it inside out. That look of fear just glassed over their eyes and you thought oh, now we're in it."

"I think the way SIAST has designed their program with scenarios and exams combined and case studies, it's a winning combination. What they're doing is good, it's serviced our province for how long? And it gives you a good overview. For those people who aren't book smart, they get the scenarios. As far as electronic simulations, I can't see what the use would be in the use of them, really, I don't."

1.2.4 Approved credit list

Participants were told that some jurisdictions have an approved credit list and were then asked who, in their opinion, should decide what credits are appropriate for the credit list. Some felt that it was a job for the governing body but most felt that it should be a collaborative effort of business owners and managers, practitioners, and SIAST representation. This group could be coordinated by the College. They indicated that all components were important including relevance to the job, costs associated, and practical learning (avoiding overlap with course topics that already exist). Participants felt that anyone could come forward with a topic that they felt was relevant. The one thing they did agree upon was that some of the current materials were badly outdated and in need of review.

"Right now SaskHealth … Where they come up with their list, I don't know."

"This might be a little bit peer orientated, too."

"Well right now SaskHealth sends that list out that you follow, right? Or whoever puts that list out. It hasn't changed, though, since I started… been in place since 1987… I think you would have to go through the governing body. Saskatchewan College of Paramedics… maybe run it through them. They are going to be the governing body."

"I definitely like the idea of SPA being the licensing body, setting out what we should learn because it's ourselves, our peers that are gonna be members of SPA. They're the ones who are on the street. They're the ones who know what our skill set is, they know what skills we need."

One participant did not see the need for a committee. He indicated that practitioners had enough free time to search out topics on the Internet and self-teach.

> *"…We have enough time to investigate those things that we're interested in if we really want to ourselves. And we have enough… I don't have any problem with the criteria that they already have. And we have lots of room in there in which to maneuver and teach whatever we think is practical."*
>
> *"… I think this program should be clinician driven and not employer driven. And I think the clinicians will be able to, should be able to decide that…"*
>
> *"Yes if the Saskatchewan Paramedics Association can break off and become its own entity, and governing body, and have SaskHealth in there, it would be perfect as far as I'm concerned. And there's a lot of paramedics that know their stuff, they're realistic about what's going on."*
>
> *"Another avenue would be my regional hospital, because we do have a good working relationship with the hospital like every rural ambulance does. If I needed that education I would go to them and say "Look, I need this, I've cleared it with Merv, can I practice this skill within your hospital so I can master it because I may not master it in 6 months in the back of a unit." So that would be another avenue I would go, would be the regional hospital and nurses that I work with on a daily basis."*
>
> *"The only reason that I think it needs to be somebody from management on there, and I think educators definitely would be in on it too… it has to be the whole rainbow of people. And the reason being is because the RMA was a really good example of that. A few years ago they had passed, and I can't remember what it was, they said you had to have this RMA (Regional Medical Advisor) on every ambulance. And so we did, and it cost us a fortune…. And so there's a group of doctors decided we needed to do this and it cost us a bunch of money to do it. Having employers there, at least we're the ones paying the bills. So we should at least know and challenge them, "Okay, you prove to me why you need that." Because you let a bunch of clinicians or just a bunch of doctors or just a bunch of the same group, it's all the same thing. You need to have people challenge one another. So I think you do need that spectrum of people at the table."*
>
> *"….Sort of centralized group where a committee of three answered to all of you, would that be an acceptable thing? I would think so. Because you still need this standardized practice…"*

Participants were asked what criteria would be used to determine acceptance. Most felt that each case should be decided on its own merits but felt that if a good enough case were presented it would be acceptable.

> *"If someone feels that they are lacking in education in any way, they would submit that request to our EMS education committee, and they would either find a program for them or develop some sort of study guide or class or something they could take."*
>
> *"It would probably be something that would come forth from the employees themselves. If they found it important enough, then we'll put it on."*
>
> *"The science behind the reason."*

"The credit points and the way they're assigned through SaskHealth, really need to be revised and looked at. Badly. Why they get ten points for communication I don't know. It takes 20 minutes to teach. And medical legal, I guess that's what they're calling it, ten points for that. They can tell you about the pamphlet they give out, and it can list the signs and symptoms, but the really… critical incidents, that's one thing that hits EMS workers the greatest, is critical incidents. It's nowhere near that list. Like, Whoa! We need more than say, how to "ten-four" on a radio."

1.2.5 Facilitator model with shift towards practitioner ownership

Saskatchewan currently uses a facilitator model to track and monitor CME. Participants were asked if, in their opinion, this was an effective method and if not, what other methods would be equally or more effective. The answers varied widely. Some felt that because of the scheduling and the structure of the services and Con Ed that there was no other way to coordinate this activity. They felt that a central responsible person was the best way.

"It's as good as the manager wants it to be. … The facilitator can make a difference."

"I know of companies that are so astute in their education and they tend to just write off employees in terms of their points, which is a downfall, but it's not a norm. And you have to make your protocols and procedures for the norm, and try to go after the ones that don't."

"The facilitator isn't making a difference now. If they don't want it to be real, it won't be real. If they want it to be real, it will be real."

"Yes, it works for us, yes it does. Mainly because we're owner-operators and if anything happens, as much as I say SaskHealth is responsible for us, it comes on our heads. So we have to make sure that we have employees that are conscientious enough, and we have to be conscientious enough when it comes to educational points. Now, again, we're private. So I would hope that the same would probably go with the union, where you'd have someone who's conscious enough to say, "I am sorry, you missed that, I'm not writing you off. Come back and we'll talk and you go through the module with me and then you can get it.""

"Well you look at one of ours, and I'm talking about a rural setting, a lot of our EMS people, this isn't their real job. So, where's a nurse? It's their real job. They may be casual, they may be part time, but that's what they do for a living. So they're gonna be a bit more focused on making sure their license is up to snuff. And you got a guy that's swinging the end of a wrench cause he's a mechanic by trade, that's not gonna be the #1 thing in his mind. And that's where I see these guys falling behind..."

"… I think I mentioned earlier that one service says if you don't have your credits you're suspended. But each of my guys, they have their Con Ed file, it's right there, whenever they do or whoever facilitates it. The facilitator signs off, that goes in their file, they know what's going on, any time they want to know that when they sign that form it automatically gets photocopied, put into their file. Whether they do it or the facilitator does it. Somebody is looking after it. They can make the decision amongst themselves. But usually what he does is photocopies everything and leaves them on the desk, and it's up to them to put them in their file or wherever."

"I don't like the AB college; I don't like the AB system. Because nobody's really checking to see if these people are competent. All they do is an online test or they get their stuff from ACP and they write the test and they submit it, and they say "I did 50 calls in the past two years, I'm fine, re-license me.""

Some participants felt the responsibility should rest firmly on the shoulders of the practitioner. They felt that the facilitator should be involved to schedule classes etc., but did not believe it was the facilitator's role to 'baby-sit' practitioners in the learning process.

"I'll tell you, it's horrible. Because, first of all it makes it almost that there's no responsibility any more for the paramedic to look after themselves. To me the responsibility of the facilitator is to ensure that the appropriate classes are made available, and that it's scheduled. And I believe that the facilitators almost need to belong to a matrix…an educational matrix, and be part of the College. So that if you can catch those 4 classes that are available say maybe in Regina, they may be available in Moosomin, they may be available in Moose Jaw. And then you have to go get it. But instead what happens is the fourth and final class has been given and then it's October, and the facilitator says, "Oh by the way, you people haven't gotten these classes." "Oh please give us another class." And then we got to take them off car, and we got to do this and that, and we're holding their hands."

"I just think that there's more continuity to it. …You've got that person who's in charge of making sure that that standard is being met or that those modules have been done, and I just think that's a good way to do it."

"People should be responsible to get their documentation done and be recertified. And if they don't then there should be some ramifications and that's with having the wages a little bit higher. Now it's a little bit better but I mean people should be responsible for themselves to recertify. But the same token I like the facilitator because the facilitator watches and if it gets close then he says "You know, you don't get it, you're…" You know, there's a clear understanding. It's not like, "Well, I think I'm close." No, you're not close. So I like the facilitator."

"It's different from each, to each company. So our facilitator sets up the dates for classes, you show up, sign your name, this person's putting on the class. Whether you learn anything or not is not tested. We hadn't been doing that. And so this year I changed it to: Okay, you're gonna take your protocol book and you're gonna sit down with your protocol book, and you're gonna write out an essay on each particular protocol, in a fashion and in your own words you're gonna say that you understand what they're saying."

"I think there should be more onus on the employee or the learner that, "We'll offer these in this, and this is when they are." But it's their job to get the paperwork filled in, their job to send it in, rather than us having to fret around December 31st because they haven't been sent in yet and the registration's up at midnight. Um, but that's just my thing, because I get very annoyed with it."

"With the national registry and the way it works in the States was, I was responsible for everything. I had to get my facilitator to sign off saying that I did the things that I said I did. They were my witness and my physician; my medical advisor did the same thing. But I

was responsible for all the paperwork, I was responsible. It put the onus on me as the practitioner and I think that's the way it should be."

"... There should be a certain onus placed on the practitioner, but the facilitator should, you know, enable. But not bear the weight for them."

"Well, I guess on the far end of the pendulum, however you got your points it doesn't matter where you get them as long as you end up with your points and what you need, or it's something that is facilitated, again, a different use of the word, through your employer. But you are ultimately responsible, you as the learner, the practitioner, are responsible for at the end of the year looking and saying, "Okay, I have A, B, and C, I need A, B, and C. I don't have D. I need to get D. How am I going to get D? Get D applied.""

One region has instituted a regional training manager and tasked the responsibility from the facilitator. Centrally designed tests are sent out to the facilitator who administers the exams that are then sent back to the central office that marks/assesses the answers.

"... We have a regional training manager who oversees the whole training program. And all the services have facilitators, just like the rest of the province has. It's these facilitators working through that regional manager. They don't even know the test themselves. It gets sent to them the night of the Con Ed session. They do it, they don't get the answer key, they don't mark it, and they send it back. He finishes it up and lets them know where they stand. So the facilitators are facilitating. They're not put then in the position of their buddies telling them, "You know, just sign me off." Because they can't do that any more... That's what we've had in place, that's what we're changing. The reason we're making our change is because we didn't believe it was effective."

Some participants liked the idea of a facilitator and the functions that they perform but did not think that having that person in-house was the best answer. Rather, they felt that there should be a group of facilitators that represented the province that went around from service to service.

"I like the facilitator model but not in house... It just doesn't work. Because it's, well because of the system we have. [The] CME process we have right now just doesn't work...everybody's due to recertify before the end of December this year, well in January it will be the end of December in two years, and people will start working on their CME again. The whole process we have doesn't work. So you have an in-house facilitator, and everybody says, "Well, please sign me off" and in rural Saskatchewan it's so much more difficult cause you can't have that facility person and you can't pay them extra wages to be the facilitator, and no matter when you schedule a Con Ed event, you're gonna have every ambulance out and so everybody's gone... It's a scheduling nightmare and try to make it up next week and it doesn't work. So yes. You need a facilitator. How could you not? You need to have somebody to facilitate the process but the in-house facilitator I don't think works. A group of facilitators in the health region that went around or if you missed Con Ed in one place you could go to another place because everybody's the same."

Some, especially the rural services, felt that the facilitator or someone in a similar position was vital because if the practitioner was not relicensed it would cause a hardship

to the service simply because there would not be staff available to fill the positions of those who have let their license lag.

> *"I can understand where you're coming from. When you're rural you can't afford to lose people. On the other hand, why am I holding their hand? These are competent people that are trusted with people's lives. Can you not make sure your points are up? I understand that too."*

> *"There's pros and cons to both of that. For one, I can see the benefit and I see where they're thinking, "Put the onus back on the employee for their own licensing." I agree with that. But when I take a step back and look at, okay, let's look at it from a practical approach. That sets us up in a huge way to be caught with our pants down. Literally. Because if in the end we're thinking, Oh, yeah, well, I've been meaning to do that but I can't even balance my cheque book, and if I sure can't get that done… And by the way, if you don't do something for me here, then in the next 3 weeks I'm going to be without a license." And all my staff are gone."*

> *"I think it's good to have a facilitator responsible for making sure everybody's at a specific point because here they really actually make people accountable that they have to get it done. And they have to or they don't get relicensed. …Those situations in rural Saskatchewan like the Rosthern… well jeez what happens if they don't relicense?"*

> *"Especially in our area, we're very thin down here. We're such a sparse population to begin with and to demand those kinds of… It takes a lot of time to get to a lot of places. Frankly what I'm getting at is you have to cater to the people down here a bit to keep them up. I mean that's just the reality of it. And if part of that is, "I'll look after your recertification documentation…"*

> *"But they're devoted (time) as facilitator. That's the difference between rural and urban, I think, is the employer and… It's just different where we are. Everybody, because of the length of hours people have to work. You know, they work 24 hour shifts and it's just not a good system with the facilitators in rural Saskatchewan …It's a big job, and the person who's had it for five years doesn't want to do it any more so the younger staff does it. But the guy who's been there for 10 years, he doesn't want to listen to the new guy. An in-house facilitator doesn't work in our situation."*

Some participants suggested that the College take over the responsibility for scheduling of classes, development of exams, and ensuring that all practitioners had everything in order at the end of any given licensing period.

> *"But it could be achieved very easily, if the SPA put on a website the dates who's having the in-services and where, then anybody can attend. Nobody's saying nobody can't attend, it's just the info is not being shared, that's all."*

> *"Because right now we have to make up our own exams and… All these things are obstacles for any facilitator. They look at the job and… You know, I have to congratulate them because they do a better job than I would do in the same circumstances year after year after year. And every year they go all over the Internet and make their own exams to present to the staff. If the College of Paramedics had sample tests that they could send out to the facilitators and locations where alternate courses would be taken, that would be terrific."*

1.2.6 Modules for CME

Participants were asked to give their opinion on module delivery methods. Internet, DVD and Telehealth were given as examples. Most felt that all delivery methods were good but felt that some were more useful depending on the learning. One method, Telehealth, was not viewed as really useful because most participants did not think they had ready access to the service or did not understand how it worked.

"All of the above."

"All of those things are good but in addition to that I'd like to see hands-on demonstrations and just practice. If you practice with your equipment, and again, because of the small rural services with the stable staff environment which is, I don't know what it is right now, it just doesn't get done. People get tired."

"I see it as an option for some staff. When you're talking medical-legal, there's an excellent way to deliver that education. Pop in a DVD and have somebody talking. Or do a Telehealth situation where you can ask a question to a lawyer and they can interact and get back to you. That kind of thing, I can see it being very effective. But for doing something like shock, you might have a DVD for the lecture part of it but there still needs to be that hands-on, how do we apply this knowledge."

"…When I'm writing a test or whatever the assignment is for that particular model, I still have to go and do the practical side with my facilitator in the group setting. It would have to be married together, those two. That's just my thoughts on that."

"Actually the ones I really liked were from the fire services. Pulse was one of them, and I can't remember the name of the other one."

"Like we used to get the tapes through SaskHealth, and they're like 50 years old. If we had a little bit more modern stuff that would be great too."

"Again you have to think about the individuals utilizing. We tried it. We actually tried developing our entire in-service program on interactive Internet. And you can fool it, you can do whatever you want with it. I still think you got to have somebody who knows…"

"There's a big gap too, like I know our average age of EMS staff is not too bad, it's 47 years. Not even all of them know how to turn on a computer to be quite honest, and we don't have high speed Internet in all of our communities. That creates significant challenges with dialup. And we don't have computers everywhere yet."

"What we found that works the best is getting together as a group and we go through the module that is presented, and we allow for free discussion. And that's where the best exchange of ideas comes along, cause that's when you can say, "This is what happened on a call that is similar to this. This is what I did." And then we have other staff who will say, "Okay this is what I did instead, this is what worked." So, because we come from varied backgrounds, the exchange of information is more helpful sometimes than we have in the module. For us we find that works the best. It's just a very good session about it."

"We have a problem with it because in our area it's hard to come by. Like in Gravelbourg, right now anyways, Five Hills has all kinds of Telehealth programming, but for us to get it through our College and our Regional College, they're struggling to be able to access it for us for some reason. I don't know why."

"I don't think Telehealth is the way to go. Because I don't know if everyone has access to it."

"... Come into Regina for a Con Ed. That's what we've been doing now, and saying, "You're welcome to come in for any Con Ed, this is [how] we're doing our stuff." That's a long drive. I would rather do it through Telehealth And I think a lot of stuff can be done through Telehealth."

Some participants felt the delivery method was not as important as having a skilled instructor.

"My question I would put forward is the product is only as good as the receiver and the presenter. So it's gonna take somebody that's got skill issues. You can give them the best information, [but] if they can't interpret it properly, is there gonna be someone at the other end to help them...?"

One participant indicated that their service did not access learning aids except for the Internet. He indicated that because the modules currently in place were so badly dated, the Internet was the best resource for their practitioners.

"Yeah, the guys wouldn't watch that unless they had to. I guess we really haven't used the resource, the DVD resource, etc., or even the VHS resource as much as we used to because procedures have changed and so those are old. And so they can be kind of misleading to a certain degree anyway. I don't think, you know, in this world that we're really short on resources that we couldn't find ourselves, because we all have the Internet, we all have access to whatever we want to download. If we really wanted more information, if we needed more...you know what the problem is? We really don't need more information to do our job. Our job is very basic."

1.2.7 Inter agency sharing of Continuing Medical Education information

It has been suggested that CME information be centrally stored and accessed by the learner or educator depending on need. Participants were asked to comment on the effectiveness of that idea.

"...You've got to have someone who's recognized as an authority."

"I think that would be excellent."

"What about if the Saskatchewan College of Paramedics had a person sitting there and you phoned and said, "Okay, I need this DVD, I need this, I need this in this format." And they sent that out. Or you want to access this on Internet. I see value in having that; there are just a lot of logistical questions around it. But I see it being valuable and a great tool."

"And that's what I meant about a group of facilitators. If you could have Emergency Childbirth in Meadow Lake, North Battleford, Maidstone, Lloydminster. I mean like, if you missed it in one place, you could go to another place. And if the facilitators are the same people or the same group of people so they can sign you off. Then you could go back to your own service, to your own facilitator and say, "I got it.""

Some participants did not feel that a centralized approach would work.

> *"Just try and control the format, that would be a nightmare."*

> *"For us I don't think that centralization works. Whether you do it by Telehealth or centralized by in service, I don't think that works for us. I know that we've had really low turnout for that, for Telehealth. Really low. Nobody wants to go. And why, I don't know, but nobody wants to go."*

Some felt that this would be an excellent way for different services (i.e. EMS and FIRE) to share resources and to enable communication and development of a learning relationship.

> *"The other problem right now is that because our guys don't see the fire fighters who are sent on the calls they look at them kind of weird, thinking: "You guys don't know what you're doing." But if they're actually in a classroom with them communicating, and the fire fighter is sharing that he does know what he's doing then that level of confidence is… But I'd say right now there's very little confidence because… They're dealing with strangers… And as one guy once put it in court, "All you fire fighters look the same. Once you start getting all the gear on, you all look the same." So that's why it's so important that they need to be part of that community."*

> *"I think it's a cost effective way of doing it, I know speaking from the volunteer fire fighter's part. Like if we want to do certain training, we just call the fire college up and we can access all kinds of tapes and information on a certain subject. So if we had the same thing, up to date… Like we could do that through SaskHealth, but the tapes were so outdated it was terrible. But if we had a current system and… Like, every little service can't afford to buy $2,000 worth of educational DVDs or tapes or… I guess there would have to be a few copies so that you know, everybody could access."*

Some felt that a centralized library already existed in the form of SIAST. One participant indicated that he felt SIAST should enable graduates to access information on an ongoing basis. Some felt that the information should be housed with the College of Paramedics.

> *"I think we should be accessing SIAST. Because we're helping SIAST through our taxpayer dollars… It's not a private company, it's a government, at least funded organization and our EMS people went to those schools, so why can't we access their stash of information. And not that they don't have it in our books either, but I guess every 3 or 4 years they change the books so that somebody can make some money, I guess."*

> *"There should be access anywhere in the province."*

Some participants felt it was a valuable concept but did not have any idea where it should be housed.

> *"I would have more faith in the College of Paramedics than I would in SIAST."*

> *"I guess I'm gonna have to disagree with you a little bit on the SIAST thing because that's where I think we find our best practices. And they are privy to the recent research, and the best practice and what other places are doing and why. … I guess SIAST does give us the best practice in a lot of cases. It's hard to find without using SIAST."*

1.2.8 Transparent layout of requirements

Participants were asked the type of information they would like to receive regarding CME requirements. The new Nova Scotia model was used as an example. All participants felt that the more information sent out the better. They indicated that the information could include courses available, how many credits were given for each, if the course was mandatory or not, and a list of locations and dates of the courses were being offered. Most participants felt that this was a role the College should be filling.

> *"That would be wonderful. Because I don't know if it's changed but I know when I graduated that was not available to me. I had to learn from my employer. But as a PCP or an EMT, if I was handed information saying, "Okay, this is what you have to do" that would be great. It puts the onus on you to make sure you're getting that."*
>
> *"I think the College needs to do something similar to what Nova Scotia is doing. The College needs to tell us what it is that we need to get to be licensed and where those courses are."*
>
> *"Myself I'd like to see the College of Paramedics sending that information out. If they're going to be the governing body and be about registration and competencies and I'm assuming it would evolve into protocol eventually. That's who should be sending that out rather than the individual RHA's but again, still with some organizational autonomy on what's to be counted."*
>
> *"…SaskHealth hasn't changed. So why change out a letter that's been the same for the last 25 years?"*

1.2.9 Other issues and comments

Other issues were raised at the time of the focus group that may warrant review but do not necessarily fit into a specific topic area. Those comments are listed below in no specific order.

> *"Well, I think we talked about them. But I think that the ones… The system has to be clinician driven not employer driven. I said they're the people that are on the street, they're the ones who know what's going on, they're the ones who know what's needed and everything. And go from there. And the other issue is less paperwork."*
>
> *"There's a concern I have about Saskatchewan College of Paramedics managing…. the Alberta College of Paramedics in the testing. I don't know if they want to be a tester. And my example is in the ACP, licensing, issuing licenses only after a student has passed their exams, so a student may have been an honours student in the program, in the PCP program, and graduate in November and they can't write the exam until February and they fail it. And they pay $300 for that exam, and another $150 for the next exam, and they can't practice until they get the license, and write their exam and do their scenarios."*
>
> *"Right now in Five Hills we're trying to do some of the stuff we're talking about today. Like just last week I got a notice from Ray that these courses are going to be offered at a certain time in Moose Jaw, so that if my staff want to go in and take part, or any of my FRs, they can. So I mean, we've talked about that, I think that's a good idea. I think for*

rural services… I wish it would work that we could come in and do some time in Regina or Moose Jaw to keep up our skills but it's just going to be such a nightmare for our service. Like I had to scramble to find somebody to work for me today so I could come to this meeting and I have the same thing… There's all kinds of meetings to go to and to find staff to replace, especially in rural, you know it's tough. So if we could you know, have that central list and there's something going on in Assiniboia, and something going on in Moose Jaw, my staff can travel there… it's not that far. Moose Jaw is an hour away, they could go in for the night. We have to get services working together more too. Like I've been in Gravelburg for 15 years and I've tried to set up stuff with my neighbour and I can't. I mean, that's not right.

And what I'm focusing on is our side that we can control because we have the responsibility to see that these people are trained and are able to perform when they're on their calls. So what we do find from time to time is people come to the Con Ed session, it's a matter of sitting there and half an hour later, they're walking out the door getting their three hours of pay. And there's no documentation, there's nothing… And we know, cause that… We just ran about a month ago… What we did was we tested the whole region at the same time at the 11th hour on Monday night. At 7:00 we strategically placed people in the region, and brought the ambulance people in, all the same, so there was no phone calls, nothing to be made, and they were all given an exam to test their protocol knowledge. And then we have a database where we can circulate different questions so there's no exams [that] are the same. And we took them back and graded them. We needed to establish a baseline of where these people are. That was our benchmark so that we could tell where we needed to take our training. …We find some of the weaknesses are the protocols themselves out there. I mean everyone knows where they are, but they're not necessarily embedded into the training on a regular basis."

"…When SPC takes over, I hope they do that because then they will become more than the SRNA… The SRNA, the only thing I've ever seen them [do] is if somebody gets an incident report or incident reports done on them and it's brought towards the SRNA to professional standards, and the SNRA says, "You're out of here." That's what they do. They basically kick people out of the organization, which is fine. But they don't have any Con Ed component, really. Which would make SCP more real to their constituents. Which would be good for them. But of course to afford that is a provincial government matter and it says the provincial government should study the fact that we want what's best for our taxpaying public, and to assure that EMS is providing quality in the field, and hey, BC's got a system that works and this is what it costs. If it cost them that, it will probably cost us that. Let's fund it accordingly."

"You know why I'm here? Because I paid to be here. And I appreciate that you ask my opinions and that it's open. And I hope it does become something that's real. But I understand where most of my guys are coming from… But if SCP gets into really being hard-assed about meeting certain benchmarks, then it will matter to these guys. It will matter. That's when they will start paying attention. But if they don't do that part of it, if they are going to be a professional body, I think they should do that. Cause that will make them relevant to the average employee. The fact that you don't follow protocol one day and you get kicked out, like an SRNA-type situation, that's the only time you hear from SRNA. But if you've got to every year meet certain benchmarks, that would become very real to these people whether they pay their dues or not. They got to meet this… and they'll know this organization. They might be more interested because of that. Cause they gotta deal with it day by day or year by year at least and meet criteria. And they'll be very

interested in who's setting those standards… So that could make the education part… very real for SCP. But if they don't get involved in that, people will be, "This is just another bureaucracy that I gotta leap through in order to get what I want.""

"With the fire department we do get called out for Cardiac Arrest, we get a lot of hands-on with Regina EMS with that, like serious calls. But it's… the good calls are there for us but the quantity is down. But the good calls are there because we do the serious calls, especially cardiac arrest or car accidents."

"…You may be FRs but you're actually looking after that patient, and that's what we're talking about."

"We have a bit of a problem with that … The problem with our joint training is we do all of ours usually on our days off. So we'll do it 4 times, the same course. We'll offer it 4 different times, and fire is more than welcome to come and join us. Usually most of your guys come in on a day on. And they'll send us a rescue truck or whatever so you've got just a small part of the department and they could be gone in no time flat because of a call.

"We do as much training as we can with the fire department. Mostly it's rescue calls that we work together. They'll do scenarios on cars and stuff and we'll assist them and show them what we need and stuff. As far as attending for cardiacs and that, they don't. They do their own. Mind you there's 4 of us from EMS that are on the volunteer fire department, too.

"That's where like in Moosomin, we have certain operating room days there that the doctors there, they more than welcome our guys to scrub up and come in to do the IVs and everything, to do their advanced skills and to keep them up and everything and that's something we're very fortunate to have."

"When I worked with St. Albert Fire in Edmonton there, for the paramedics with the fire department there, every six months they had to do a day in OR to keep up their tubing skills. And they would go and do a day, and do so many tubes and do stuff like that, which was also good too. But that stuff you can do with that simulator and all that…"

"What would be excellent, but I don't think it could ever fly, is if you could have a learning fair where you would have practitioners come in from rural areas and do almost a refresher on the weekends, and you can pick what one you want to go to and you can come in and do the simulations at MD. You can do this, you can do that, where you know your areas of expertise are going to be. Like, we don't deal with pediatrics, we hammer our pediatric staff because one of these days we're going to get a call and they'll be like chickens with their heads cut off. A lot of what we deal with is cardiac. If we could somehow design something like that in Saskatchewan where it would be 50 people who get to go to this course in a weekend, and you get to do this, it would be great to get that kind of hands-on experience."

"From my perspective, I see a lot of problems with that, because I have the rural staff that don't want to have to travel. They want it in their community, the education right there. It's too much of a hassle. They work Monday to Friday at other jobs fulltime, and their weekends they have to spend on call and they don't want to go into the city and spend a weekend in there. Interface, you know, we're willing to send 25 staff, and the most we've ever sent is eight paid."

1.3 Summary

The following are some general observations and a brief summary of the focus group responses.

Tracking patient contacts

Most participants were in favour of tracking patient contacts but not as a mandatory part of licensing. They felt that call volumes were so drastically different between urban and rural that it would be very difficult to set benchmarks. Participants thought that tracking contacts would be very useful for Con Ed. It would allow the practitioners to identify areas where they excel and areas that require attention.

Written evaluation of skills

There was very little support for this suggestion. Most indicated that testing was viewed as a negative thing and it would make their lives stressful. Some participants (Employer) also indicated that it would add to an already heavy paper. Most felt that verbal activity and group participation were a better way to learn and assess the learners' retention.

Simulation

Almost all participants felt that scenarios were an excellent learning tool and were in favor of the more costly simulations although few had first-hand knowledge. Most participants indicated that learning required theory and hands-on experience.

Approved credit list

Participants all seemed in favor of an approved credit list. Most felt the 'approval committee' should be made up of practitioners, employers and the College. Participants thought that any member of EMS should have an opportunity to submit a suggestion to the committee providing that they could show a need. They also indicated that because different areas had different focus (fire, urban and rural, agriculture, mining and oil and gas etc.) it would be a good opportunity to expand current knowledge base. They also indicated that the committee could draft the requirements for submission.

Facilitator based model

The majority of participants were strongly in favour of the facilitator. Most participant had absolutely no desire to take on more of the responsibility for their learning and licensing requirements. Participant did indicate that it might be useful if all facilitators performed the same tasks at the same level and that standardization of the process may be useful, particularly in the more rural areas where there may not be a 'dedicated' facilitator.

Modules for CME

Participant were in favour of most delivery options but seemed to show a preference for DVD. They felt that the internet was a good resource but not all practitioners had access or the basic skills to make it really useful. Most were in favour of telehealth but few participants had experienced it first hand.

Inter agency sharing of CME information

Most participants thought inter agency sharing was a great idea. They indicated it would allow more reliable access to learning tools. Participants also indicated that it would allow sharing between agencies, particularly EMS and Fire; both of which have well developed learning process and material.

Transparent layout of requirements

Interestingly, some participants indicated that they had were not familiar with the letter that is sent annually outlining requirements for licence. Most indicated that their facilitator handled the whole situation. Of those who had experience with the letter of requirements, all were in favour of a more detailed overview of requirements including learning opportunities, their times and locations as well as mandatory and optional learning and the credit value.

2 Communication Strategy June 2007

Development of a communication strategy is an essential component to the SCP. It is becoming an increasingly effective voice for its members, the Paramedics in Saskatchewan. An essential component of communicating effectively for a specific group is equally effective communication within the group and other related groups that are effected by the decision making process.

The SCP has, to this point, had a fairly relaxed communication process in place relying on practitioner interest through the website, word of mouth etc. to share its message. The message has in the past few years become much more focused and will have a far greater impact on the practitioner and needs to be communicated in a timely and effect manner.

To that end the Phase II working group came together at the end of the Phase II project with the following questions:

- Target groups: Who do we need to communicate with?
- Message: What do we want to say to the target groups?
- Communication tools: How should we communicate with the target groups?

The following points outline the process that the SCP intends to put in place.

2.1 Communication Process:

- The information gathered throughout the project will be shared with SCP members and guests through regular updates to the SCP web site. Upon completion of the project a document will be developed outlining the process as a part of the communication process

Target groups for communication: In order of contact priority

- **Practitioners**
  Registered EMR's, EMT's, EMTA's, Paramedics
- **Employers**
  SEMSA, SAFC, Industry, RHA's/northern clinics
- **Unions (Exec.)**
  HSAS, SGEU, CUPE, IAFF, SEIU
- **Health Professionals (SK)**
  PAC, SPFFA, Professional Regulatory Bodies, Military (DND) SAHO, Educational i.e. SIAST, SAIT
- **Public**

2.2 Message to Communicate

2.2.1 Recommendation of Steering Committee for Phase I Sector Partnership

2.2.2 New CME Proposed to all practitioners

1) Point System – as required presently
   - Credits from Approved List – open to practitioners input yet requires approval from College
   - Mandatory Credits, non-mandatory credits
2) Patient Contact (#'s, types of calls)
   - not mandatory to licensure but will be a determining factor in Con Ed content
   - modules to identify gaps in learning
   - remediation through simulation

3) Role of Facilitator will continue to exist however will be redefined if and when the proposed changes take place. For those without access to a facilitator a system will be put in place to meet the needs of all practitioners in all areas, such as:
   - Industry
   - Northern clinics
   - Ambulance
   - Fire
   - Military
   - Rural
   - Urban

2.2.3 Legislation update

- Third reading passed May 8th, 2007
- Waiting for royal assent (this transfers Bill 8 into the Paramedic Act)
- Proclamation required – date pending
- Regulations are already in place to make transition
- Proclamation will allow powers within the Act to access membership data to make communication much easier

2.2.4 Communication format - Key points

- Keep communiqué informal
- Short (2-3 paragraphs)
- 2 initiatives – legislation and CME/ Sector Partnership
- website info
- membership card
- communicate how often newsletters will go out

- announcement of town meetings to be held at a later date

Additional Communication information to be included

- Send out full Paramedic Act
- Send out full Sector Partnership report
- Membership cards

2.3 Communication Tools

- Email
- Mail – yearly licensure mail out to all members
- Q&A on website
- Telehealth
- AGM in fall
- SAHO may assist in communication to RHA CEO's
- Town hall meetings throughout province – will need to be set up to discover how needs will be met

2.4 Communication Timelines

- Practitioners contact upon project completion
    - Letter 2-4 paragraphs re:
        - Legislation passing
        - Royal Assent
        - Next Steps
        - Membership cards

- Employers/Unions
    - 2-3 days later
    - Letter 2-3 paragraphs
        - Info on legislation
- Health Professionals and the Public
    - Wait until all is official re: legislation and transition
    - Timeframe for Communications
        - newsletter 2-3 times per year
        - Website updated monthly

2.5 Introduction and Overview of Phase II Sector Partnership Project

Upon completion of the Saskatchewan Paramedic Association (SPA) now the Saskatchewan College of Paramedics (SCP) Phase I Sector Partnership a series of recommendations was drafted by the sector partnership steering committee to address some of the issues that were raised by the research. The two recommendations that were addressed by the SCP as part of Phase II are listed below in their entirety:

> Develop and implement a continuing education model to coordinate and promote continuing education needs and opportunities in the sector. This process would include:
>
> - A review and enhancement of existing continuing education guidelines to meet the registration needs and the needs of employers and employees in the sector;
> - A review of current continuing education practices within all the health authorities in the province;
> - A review of current continuing education practices and standards of other professions within the province and other jurisdictions; and
> - A review of Recognition of Prior Learning (RPL) processes that facilitates the identification and documentation of experiential learning and continuing education, to the creation of professional development plans. (to be completed at a later date)
>
> Develop a comprehensive communications strategy to support the SPA in:
>
> - Providing community stakeholders, employers and employees an understanding of the work that the SPA has done in partnership with Saskatchewan Health in working towards the SPA becoming a self-regulated professional body;
> - Promoting and marketing continuing education opportunities and possible funding options that may be available to support education and career laddering; and
> - Providing community stakeholders, employers and employees with an overview of the work completed and being undertaken by the Sector Partnerships Steering Committee.

These recommendations were partially addressed in Phase II of the Sector partnership project. An overview of that process, including an overview of the components and the suggested next steps is included in the following pages. This document was compiled to serve as the project overview for the communication strategy.

2.6 Literature Methodology and Overview

The Saskatchewan College of Paramedics (SCP) is striving to become the regulatory body for Paramedics in the province. At present there are in excess of 1500 registered Paramedics in the province plus an additional 1750 first responders. Membership in the association is currently voluntary.

The SCP requested Phase II funding under the Job Start/Future Skills Sector Partnership Program to assist them in moving forward and implementing Continuing Medical Education issues identified in the Phase I Sector Study. Currently continuing education is at the discretion of the employer and may not always be meeting the needs of the employee or the sector. The desired outcome of Phase II will be a clear, concise, and consistent continuing medical education model for this sector.

The College feels it is crucial to develop a Continuing Medical Education model to support practitioners in acquiring the training and education needed by all Paramedics so that they can not only be front line emergency providers but also can complement health care partners in emergency departments, hospitals, and clinics. Through this process, partnerships with training providers will be enhanced to ensure that the appropriate training is available and also to explore alternate methods of training delivery especially to meet training needs in the North. With this in place all practitioners will be able to move towards common education goals following a clearly defined path. An enhanced partnership with Saskatchewan Health and the EMS sector will also work towards improved mobility of the workforce across the province.

Literature review

This literature review will provide an overview of CME models and practices at a provincial, national and international level as well as interdisciplinary levels. Continuing Medical Education is mandatory in Saskatchewan but the content is at the discretion of the employer/trainer/facilitator.

The SCP believes that it will become a self regulating body early in 2008; when this becomes a reality. Practitioners - not employers - will become responsible for their CME. The model should be in place when this happens. This project will take the current framework, expand and enhance it so that it can be put in place when the anticipate legislation becomes reality in 2008.

Continuing Education Models – Compare and Contrast

The point of this literature review was to compile existing information (websites, existing documentation, etc.) so that it could be compared to the current Saskatchewan model. This has proven to be more challenging than originally anticipated as jurisdictions differ widely.

Some jurisdictions:

- Have detailed, well laid out policies and procedures.
- Have policy and procedures that are being challenged to varying degrees.
- Are in transition changing processes to address redefined dynamics of self regulation.
- Is not self regulating, but investigation the implications of becoming so.

There is an enormous amount of information available but very little of it is standardized in its presentation. This posed challenges for development of our comparison model; What to include? What to exclude? Through an elimination process Mercury Information Services chose an outline that is comprehensive and easily understood as a base, bringing information from other jurisdictions into that format as available and applicable.

The following definitions are provided through the Saskatchewan Ambulance Continuing Education Program and will by used to facilitate understanding:

⇒ Registration – the official act of recording a list of names, personal information and qualifications of pre hospital care providers.

⇒ Licensure – a license or permit from government that allows an individual to function within a defined scope of practice.

⇒ Certification – official documentation that an individual has fulfilled specific requirements of the prescribed training program or course of studies.

⇒ Continuing Education – a philosophical approach to facilitation, professional development, ongoing training and skills maintenance.

2.7 Focus Group Methodology

As a part of the Phase II process a working group of industry members has been brought together to develop a new 'draft' framework for CME in Saskatchewan. To assist this group with their task a literature review providing an overview of Continuing Medical Education models and practices at a provincial, national and international level as well as interdisciplinary levels was completed. The literature review is attached as an appendix to the final report.

Continuing Medical Education is mandatory in Saskatchewan but the content is at the discretion of the employer/trainer/facilitator. The SCP believes that it will become a self regulating body in 2008; when this becomes a reality the model should be in place. This project will take the current framework, expand and enhance it so that it can be put in place when the anticipate legislation becomes reality in 2007.

For this draft framework to be most effective the input of practitioners was imperative. To this end 10 Focus Groups were held (5 with Employees and 5 with Employers) throughout the province in the November/December of 2006. There were 34 participants in total, 12 Employer and 22 Employee. The focus groups were held in

both rural and urban settings. These included Saskatoon, North Battleford, Swift Current, Weyburn, and Regina. While the groups were held in the aforementioned locations many of the participants drove in often adverse weather conditions from the surrounding areas to participate.

The following communities were represented at the 2006 focus groups:

- Saskatoon,
- Colonsay,
- Biggar,
- Dundern,
- Spiritwood,
- St. Walberg,
- North Battleford,
- Cut Knife,
- Maidstone,
- Swift Current,
- Beechy,
- Weyburn,
- Creelman,
- Lampman,
- Gravelburg,
- Regina,
- McLean,
- Canora.

Participants for the Employer/Management groups were recruited for the focus groups from the database of service providers, industry representatives, and training providers. Employers were asked to post the focus group information to allow employees who did not complete the survey to take part in the process. Employee participants were contacted by SaskHealth directly because of privacy legislation. SaskHealth, as a partner in this project, sent out a letter to all licensed practitioner in July 2006. This served two purposes… privacy was protected and the College had an opportunity to invite practitioners to participate in this project. A consent form attached to the letter asked for contact information. Practitioners who filled out the consent form and return it to SCP were included in the database of potential participants. A professional recruiter was subcontracted by the project consultant to contact potential participants regarding the logistics of the focus groups. The process was voluntary at all times; employees were given an honorarium to compensate them for their time.

It was pointed out by a participant that the groups originally titled as Employer were really owners, employers, management, and training providers. The Employee group contained employees and employees who were also representing training providers. We acknowledge that the groups comprise more that employers and employees but for ease of reporting those will be the titles referred to herein.

During the recruiting process, effort was given to ensure that the groups were representative of the industry in Saskatchewan. The Employer/Management and Employee groups contained:

- Urban and rural representation at an employee and management level;
- Public and private and military services at an employee and management level;
- Training provider representation at an employee and management level;
- Industry representation at an employee level;
- Representation from Fire at an employee and management level.

The information from the focus groups will be summarized and presented to the sector working group to assist them in their work on the proposed CME model. A substantial amount of data was collected during the process. In order to make this stage of the process manageable, the information from all groups has been compiled; all employer groups were written up together and all employee groups were written up together. These documents were compiled into one comprehensive document.

2.8 Focus Group Summary

The following are some general observations and a brief summary of the focus group responses.

Tracking patient contacts
Most participants were in favour of tracking patient contacts but not as a mandatory part of licensing. They felt that call volumes were so drastically different between urban and rural that it would be very difficult to set benchmarks. Participants thought that tracking contacts would be very useful for Con Ed. It would allow the practitioners to identify areas where they excel and areas that require attention.

Written evaluation of skills
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Simulation
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would be a good opportunity to expand current knowledge base. They also indicated that the committee could draft the requirements for submission.

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Modules for CME

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Inter agency sharing of CME information

Most participants thought that this was a great idea. They indicated that it a central location, perhaps housed by the College, would allow more reliable access to learning tools. Participants also indicated that it would allow sharing between agencies particularly EMS and Fire; both of whom have well developed learning process and material.

Transparent layout of requirements

Interestingly, some participants indicated that they had no idea what was on the letter stating that they had never seen it; their facilitator handled the whole situation. Of those who had experience with the letter of requirements all were in favour of a more detailed over view of requirements including learning opportunities, their times and locations and well as mandatory and optional learning and the credit value.

3 Next Steps and Future Considerations

Define parameters of/ create process;

iv. Credits- how many needed, what each course is worth;

v. Patient Contact – driving force;

vi. Role of Facilitator.

Pilot Projects- occupational standards;

Enhance partnership with aboriginal groups and youth through job fairs, high school counselors;

Explore recruitment and retention opportunities;

Break down CME into bite-sized chunks;

Target groups who are not affiliated with ambulance; and

Create a model for communication.

Future Considerations

Development of modules in future projects

- Whether to use an already developed program;
- Develop on our own - any program would need Canadian content and would need to stay current;
- Would develop a few modules at a time;
- Would need to be hired out;
- Would need to be piloted out to see if features are working.

APPENDIX I.

LITERATURE REVIEW

Introduction

The Saskatchewan Paramedic Association (SPA) now referred to as the Saskatchewan College of Paramedics (SCP)is striving to become the regulatory body for EMS practitioners in the province. At present there are in excess of 1500 registered EMS practitioners in the province plus an additional 1750 first responders. Membership in the association is currently voluntary.

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The College feels it is crucial to develop a Continuing Medical Education model to support practitioners in acquiring the training and education needed by all EMS practitioners so that they can not only be front line emergency providers but also can complement health care partners in emergency departments, hospitals, and clinics. Through this process, partnerships with training providers will be enhanced to ensure that the appropriate training is available and also to explore alternate methods of training delivery especially to meet training needs in the North. With this in place all practitioners will be able to move towards common education goals following a clearly defined path. An enhanced partnership with e Saskatchewan Health and the EMS sector will also work towards improved mobility of the workforce across the province.

Overview – Why a literature review?

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⇒ Continuing Education – a philosophical approach to facilitation professional development, ongoing training and skills maintenance.

Saskatchewan

(Information to complete parts of the following section was provided by SaskHealth in the form of a the training facilitators binder and an information fax)

The Ambulance Continuing Education Program (ACEP) was established in 1988 to provide local, affordable continuing education for all levels of attendants. The primary goal of the program is to facilitate ongoing training that will establish a base for a high and consistent standard of patient care for all areas of Saskatchewan. The program also provides for regular in-service meetings and the recertification of Emergency Medical Technicians. Current regulations make this program mandatory for all registered ambulance attendants.

The present format of the program was conceived in response to requests from the Ambulance Industry and has been guided by significant input from local facilitators. The program emphasizes the maintenance of skills through in-service sessions and utilizes study guides that are designed to cover a wide range of circumstances faced by emergency health care providers.

Registration Renewal

All applicants are required to submit the following documentation upon registration renewal in order to maintain current registration:

⇒ Registration Application form

- ⇒ Physician's certificate (immediately prior to employment and every 3 years thereafter)
- ⇒ Copy of current BLS 'C' - C.P.R. Certificate (Valid for 2 years - recommended annually)
- ⇒ Copy of current Class '4' Driver's License (Class 4 Driver's Licenses are not required of all ambulance personnel - only of those personnel who drive the ambulance vehicle)
- ⇒ Mandatory Skills Checklist (required in order to renew registration for a further two-year term)
- ⇒ Continuing Education Record (required in order to renew registration for a further two-year term)

Annual requirements

- ⇒ Providers are required to maintain proficiency in essential practical skills that involve Basic Life Support Level 'C' C.P.R, Spinal Injuries, Lifting and Moving, and Mechanical Aids to Breathing.
- ⇒ In addition to maintaining the above mandatory skills continuing education is required of all providers. Continuing education for providers who register part way through the two-year registration term may be limited to the percentage of time remaining in the term (the term is divided into quarters).

The following is required in each registration term in order to maintain registration:

Emergency Medical Responder, Licensed Practical Nurse

- ⇒ Maintenance of skills proficiency in C.P.R.- Level 'C', Spinal Injuries, Lifting and Moving, and Mechanical Aids to Breathing.
- ⇒ Additional 50 credits of approved continuing education through local ambulance Continuing Education Program(s).
- ⇒ Additional 50 credits of approved continuing education through local ambulance Continuing Education Program(s).

Registered Nurse

- ⇒ Maintenance of skills proficiency in C.P.R. - Level 'Ct, Spinal Injuries, Lifting and Moving, and Mechanical Aids to Breathing.
- ⇒ Additional 30 credits of approved continuing education through local Ambulance Continuing Education Program(s).
- ⇒ Additional 30 credits of approved continuing education through local Ambulance Continuing Education Program(s).

EMTs Functioning as EMRs (ambulance personal)

- ⇒ Maintenance of skills proficiency in C.P.R. - Level 'C", Spinal Injuries, Lifting and Moving, and Mechanical Aids to Breathing.

⇒ Additional 80 credits of approved continuing education through local Ambulance Continuing Education Program(s). Additional 80 credits of approved continuing education through local Ambulance Continuing Education Program(s).

EMTs in other environments (i.e. Occupational safety, Fire Systems)

⇒ Maintenance of skills proficiency in C.P.R. - Level 'C'

⇒ Completion of industry specific recertification program or alternate refresher program approved by Saskatchewan Health.

⇒ Completion of industry specific recertification program or alternate refresher program approved by Saskatchewan Health.

Emergency Medical Technician-Advanced (EMT-A)

⇒ Current CPR "C"" level or equivalent certification.

⇒ Spinal injuries proficiency through approved Emergency Medical Technician Continuing Education Program or as outlined in other approved EMT/CE program.

⇒ Sixty (60) additional continuing education credits described in the Ambulance Continuing Education Program or as outlined in other approved EMT/CE program.

⇒ Basic Trauma Life Support (BTLS) Certification or a BTLS Refresher Certification course that has been approved by the Basic Trauma Life Support Organization or Communality Hospitals and Emergency Services, Saskatchewan Health.

⇒ Demonstrate proficiency in peripheral intravenous cannulization, manual defibrillation, (if a manual defibrillator is being used by the service), Combi-Tube placement, and the procedure for placement of rectal Diazepam.

⇒ If the service is using an AED, the EMT -A must remain current in its use based on the guidelines of the Canadian Heart and Stroke Foundation.

⇒ Sixty (60) additional continuing education credits described in the Ambulance Continuing Education Program or as outlined in other approved EMT/CE program.

Emergency Medical Technician– Paramedic (EMT-P)

⇒ Maintenance of skills proficiency in C.P.R. – Level 'C', and Spinal Injuries.

⇒ Additional 30 credits of approved continuing education through ACEP.

⇒ Advanced Cardiac Life Support (ACLS) certification or ACLS refresher certification approved by the American Heart Association or the Canadian Heart and Stroke Foundation.

⇒ Basic Trauma Life Support (BTLS) advanced certification or BTLS advanced refresher certification approved by the Basic Trauma Life Support Organization or Saskatchewan Health.

⇒ Must demonstrate proficiency in endotracheal intubation on adult and child intubation mannequin. Other ALS skills require practical maintenance through local medical advisors. Additional practical and clinical time may be required in order to demonstrate ALS competencies to the observing physician.

⇒ Additional 30 credits of approved continuing education through ACEP.

License evaluation

⇒ Ambulance attendant registration terms and Emergency Medical Technician Licenses are valid for a maximum of two years; the date of expiry will be indicated on the certificate of Registration issued to each ambulance attendant and licensee. Registrants must apply for renewal prior to the expiration date noted on their certificate of Registration.

⇒ Copies of all required documentation must be submitted in order to be eligible. Registration is the individual attendant's own responsibility. Requests for changes in qualifications must be supported with copies of training certificates.

⇒

License review

⇒ Information not currently available

Documentation and Audit process

⇒ It is the responsibility of the individual to have documentation completed and returned to their training coordinator/supervisor who w ill forward a copy to the Registrar, Acute and Emergency Services Branch, Saskatchewan Health and the Regional Medical Advisor for the ALS service/district.

Patient Contacts

⇒ Information not currently available

CE as a supplement for patient contacts

⇒ Information not currently available

Continuing Education

The Ambulance Continuing Education Program (ACEP) was established in August, 1988, to provide local, affordable, continuing education for all levels of ambulance attendants. This program is designed to ensure basic skill maintenance and provide for recertification of Emergency Medical Technicians that are active in the pre hospital care sector. ACEP should also facilitate regular meetings that could benefit local ambulance personnel and administrators in other organizational areas.

The program consists of three main components:

Category A	Mandatory skills
Category B	Credits for continuing education lesson guides
Category C	Credits for other approved continuing education courses, workshops and industry involvement.

Category A includes the mandatory skills - spinal immobilization, lifting and moving techniques, and proficiency with mechanical aids to breathing (suction and oxygen equipment). All personnel are required to maintain C.P.R. certification at the BLS level 'ct.

Advanced Life Support (ALS) providers are also required to maintain proficiency in ALS skills. Advanced Cardiac Life Support, Basic Trauma Life Support, and proficiency in particular ALS skills are required of ALS providers in each registration term.

Category A, which represents the maintenance of particular mandatory skills, is not assigned continuing education credits.

Category B includes lesson guides for continuing education in a number of patient care and EMS areas. Each lesson is assigned a number of credits for continuing education tabulation at the end of a registration term. Attendance at local inservice training sessions utilizing category B lesson plans will be the primary continuing education activity of ambulance attendants. Total available lesson plan credits significantly exceed the minimum credits that are required at any training level.

The various subject areas, training material, and resource readings generally coincide with the Emergency Medical Technician program for continuity and consistency. Local training emphasis will determine which lesson plans are utilized. Where the subject area warrants, these lesson plans include practical skills checklists.

Category C allows for continuing education credits to be earned through other training courses, workshops and conferences. Instructor/trainer involvement and membership in industry associations may earn individuals credits in this section as well. There are limits to total credits available through Category C. In order to be eligible for credits, courses and conferences must be approved by Saskatchewan Health.

Ambulance training facilitators, nominated by each ambulance operator, are given the responsibility to coordinate the delivery of the Ambulance Continuing Education Program at the local level. Ideally, these facilitators will be active attendants and provide much of the training expertise.

What is CE Eligible
How to submit for CE credits

⇒ It is the responsibility of the individual to have documentation completed and returned to their training coordinator/supervisor who will forward a copy to the Registrar, Acute and Emergency Services Branch, Saskatchewan Health and the Regional Medical Advisor for the ALS service/district.

⇒ Ambulance training facilitators are nominated by their local operators to coordinate training and continuing education. The local training facilitator is essentially responsible to ensure that training needs are met and proceed efficiently. Evaluating and utilizing available local resources, liaison with health department officials, distributing and preparing instructional material, and acquiring and assisting instructors may all form part of the role of local ambulance training facilitators.

⇒ It must be emphasized that program coordination and the actual delivery of training sessions should be viewed as distinct and separate roles within local ACEPs. Quality facilitation would often include obtaining the best expertise locally available as other personnel in the EMS system may be more qualified to deliver a particular session.

⇒ The continuing education record (previously the logbook) is an essential part of the Ambulance Continuing Education Program,. It is used to identify and validate training activities during the registration term. Attendants are required to submit this record to Saskatchewan Health when applying for registration renewal.

Approved Credits

⇒ An overview of mandatory and continuing education credit requirements is available in Section V of the facilitators binder available through SaskHealth.

National

The following overview was taken directly from the National Occupational Competency Profiles for Paramedic Practitioners, June 2001. The competencies are used by several jurisdictions as a basis for CME framework. The information has been provided as a backdrop to the overview of the provincial frameworks. No attempt has been made to abbreviate it as the meaning would be lost. Complete documentation can be found on the Paramedic Association of Canada website. www.paramedic.ca

National Occupational Competency Profiles for Paramedic Practitioners, June 2001

This document contains a set of four integrated competency profiles that define the work of paramedic practitioners nationally.

A competency profile is included for each of the following practitioner levels:

- ⇒ Emergency Medical Responder
- ⇒ Primary Care Paramedic
- ⇒ Advanced Care Paramedic
- ⇒ Critical Care Paramedic

The Paramedic Association of Canada (PAC) introduced these practitioner levels in March 2000, together with an initial competency profile for each. This was done to promote national consistency in paramedic training and practice, and to enhance job mobility for practitioners.

The initial competency profiles were reviewed and refined to produce the new profiles contained in this document. The new profiles do not expand the practitioner roles that were introduced in March 2000. They provide a more precise definition of the occupational competencies, and better indicate how competency can be determined. The Board of Directors of PAC approved the new profiles on June 29 2001.

Practitioner Levels

The Emergency Medical Responder (EMR) has successfully completed a recognized training program in emergency patient care and transportation. EMRs are part of the foundation upon which Canadian emergency medical systems are built. They are often associated with volunteer emergency services organizations in rural and remote areas, and may be the sole provider of emergency services in some communities. EMRs may be responsible for initial assessments, the provision of safe and prudent care, and the transport of a patient to the most appropriate health care facility. "First Responders" (as found in a tiered response, industrial and / or recreational setting) may be included within the EMR level, although in many settings First Responders do not provide patient transport. The EMR competency profile does not include controlled or delegated medical acts.

The Primary Care Paramedic (PCP) has successfully completed a recognized educational program in paramedicine at the primary care level. PCPs may be volunteer or career paramedics associated with urban, suburban, rural, remote, industrial, air ambulance and / or military services. PCPs constitute the largest group of paramedic practitioners in Canada. They are expected to demonstrate excellent decision-making skills, based on

sound knowledge and principles. Controlled or delegated medical acts (Successful completion of an educational program that has provided instruction in the provision of controlled or delegated medical acts does not sanction a paramedic practitioner to implement these acts without formal, defined medical control) identified in the PCP competency profile include semi-automated defibrillation and the administration of certain medications.

The Advanced Care Paramedic (ACP) has successfully completed a recognized educational program in paramedicine at the advanced care level. Such programs often require prior certification at the PCP level (or equivalent). ACPs are most often employed by urban, suburban, air ambulance and / or military services. Currently relatively few ACPs are found in rural areas. ACPs are expected to build upon the foundation of PCP competencies, and apply their added knowledge and skills to provide enhanced levels of assessment and care. This includes the added responsibilities and expectations related to an increased number of controlled or delegated medical acts available. Controlled or delegated medical acts (Successful completion of an educational program that has provided instruction in the provision of controlled or delegated medical acts does not sanction a paramedic practitioner to implement these acts without formal, defined medical control) identified in the ACP competency profile include advanced techniques to manage life-threatening problems affecting patient airway, breathing, and circulation. ACPs may implement treatment measures that are invasive and / or pharmacological in nature.

The Critical Care Paramedic (CCP) has successfully completed a recognized educational program in paramedicine at the critical care level. This is currently the highest level of paramedic certification available. CCPs are most often associated with large urban and / or air ambulance services, and are not found in all provinces. The CCP is expected to perform thorough assessments that include the interpretation of patient laboratory and radiological data.. CCPs' high levels of decision-making and differential discrimination skills relating to patient care, result in their implementing treatment measures both autonomously and after consultation with medical authorities. Many controlled or delegated medical acts(Successful completion of an educational program that has provided instruction in the provision of controlled or delegated medical acts does not sanction a paramedic practitioner to implement these acts without formal, defined medical control) are available to the CCP. Those identified in the CCP competency profile include the use of invasive hemodynamic monitoring devices and advanced techniques to manage life-threatening problems affecting patient airway, breathing, and circulation. CCPs typically implement treatment measures that are invasive and / or pharmacological in nature.

The competencies at each practitioner level are cumulative, in that each level includes, and exceeds, the competencies of the previous level. Furthermore the competencies defined in these profiles are the minimum required at each practitioner level. Employment jurisdictions can, and frequently do, exceed these requirements.

Regulation of Paramedic Practice and Approval of Training Programs

The practice of paramedicine in Canada is regulated by each province or, in the case of federal jurisdictions such as the military, by an appropriate federal authority.

Each regulator is free to determine the scope of practice and practitioner classification system that applies in its jurisdiction. Similarly the regulator may approve training program(s) that are a prerequisite to employment.

A number of regulators are aligning their practitioner classifications with PAC's levels.

In addition to complying with local regulatory requirements, many training programs across the country have elected to participate in the voluntary national accreditation process for paramedic training administered by the Canadian Medical Association (CMA). CMA issues *Requirements for Accreditation* that include an expectation that a program ensures that its graduates possess the competencies determined by the national professional association.

CMA accredits paramedic programs at the PCP, ACP, and CCP levels. In order to be eligible for CMA accreditation, programs must identify the level that applies to them and must demonstrate that their graduates meet (or exceed) every specific competency listed in corresponding profile contained in this document.

The profiles include requirements related to the physical skills of lifting patients and performing certain other physical acts. Employment opportunities may exist wherein paramedics are not required to perform such physical acts. In some jurisdictions regulators require that an individual be fully credentialed as a practitioner, prior to entering a position that does not require such physical acts. PAC does not intend that the competency profiles be used to as a barrier to training for a physically disabled individual who wishes to practice as a non-classic paramedic. In these situations PAC recommends that educational institutions allow such individuals to complete training in relevant competencies, and provide a graduation credential that clearly identifies appropriate restrictions.

Related Publications for Educators

During the development of the competency profiles, PAC has produced some related documents that assist in defining the paramedic profession:

- Essential Skills Profile (June 8 2000)
- Links Between Essential Skills and Occupational Competencies (March 2001)

The Essential Skills are enabling skills that provide individuals with part of the foundation necessary to learn paramedic-specific knowledge and skills, and to function in the workplace. Essential Skills include the following::

⇒ Reading Text
⇒ Use of Documents
⇒ Writing
⇒ Numeracy
⇒ Oral Communication
⇒ Thinking Skills (problem solving, decision making, job task planning and organizing, significant use of memory and finding information)
⇒ Working with Others

⇒ Computer Use

In general, paramedic training programs do not include training in the Essential Skills. It is common practice, however, for programs to require incoming students to have demonstrated some degree of mastery of Essential Skills through either general educational prerequisites (such as grade 12 graduation, completion of English 12, etc) or through informal assessment (such as an admission interview process).

Certain Essential Skills areas, particularly Thinking Skills, are commonly not addressed in a formal manner through prerequisite requirements or informal assessment. Nor are they typically included as training program content. It is assumed instead that students either have developed these skills already through their life experiences, or that they will do so informally as they complete their paramedic training. Students unable to do so may fail to successfully complete their training program, or may have difficulty gaining or retaining employment.

Although incorporation of the Essential Skills is not a requirement, PAC encourages training programs to address the need for these skills in a comprehensive and formal manner, either through prerequisite requirements or through coursework within the program.

Foundation Knowledge Profile (August 2001)
Foundation Knowledge is enabling knowledge that provides part of the foundation necessary to learn paramedic-specific knowledge and skills.
The Foundation Knowledge Profile defines knowledge in two areas:

⇒ Life sciences (biochemistry, human biology, anatomy and physiology)
⇒ Physical sciences (chemistry, physics)

Paramedic training programs vary in their approach to the Foundation Knowledge areas. Some programs require incoming students to have completed specific educational prerequisites (such as chemistry 12, a human anatomy and physiology course, etc). Other programs provide this material as formal coursework within paramedic training.

Although the incorporation of Foundation Knowledge is not a requirement, PAC encourages programs to address this need in a comprehensive and formal manner, either through prerequisite requirements or through coursework within the program.

British Columbia
(The following information was obtained through an e-mail interview with the Registrar EMA licensing, Ministry of Heath Services, Government of British Columbia; it is posted on the Intranet). The government site is www.healthservices.gov.bc.ca

License Maintenance
Annual Requirements
During the twelve months ending each December 31, registrants must satisfy one of the following:

- ⇒ Minimum patient contact and continuing education (CE) requirements;
- ⇒ Minimum CE requirements and an additional CE credit for each patient contact short of the minimum required;
- ⇒ Successful completion of a licensing evaluation*; or
- ⇒ Achievement of a higher EMA license*.

*Note that in the year that a registrant successfully completes an EMA Licensing evaluation for either an initial licensing or re-licensing, he or she is exempt from the reporting requirements for both patient contacts and CE for that same year.

Licensing Evaluation

Registrants who are unable to satisfy annual practice requirements must complete an assessment by March 31st of the following period. An assessment will consist of the following components:

- ⇒ Written examination on protocols and procedures
- ⇒ Practical simulations
- ⇒ Skill Stations (if required)
- ⇒ Clinical practice for intravenous and/or intubations

License Review

EMA licenses are issued and are valid for five years. Before a license renewal is granted, all aspects of practice experience and CE will be reviewed. A licensing evaluation may be required if:

- ⇒ Insufficient patient contacts are submitted as the attendant
- ⇒ Insufficient patient contacts are recorded
- ⇒ Exposure to major areas of responsibility is not experienced.
- ⇒ An assessment will consist of practical simulations, specific skill stations and/or an on-car review.

Documentation and Audit Process

For both patient contacts and CE activity, supporting documentation is not to be submitted with the input forms. Instead, supporting documentation must be maintained and made available upon request.

Each year, EMA Licensing will select individuals at random to show proof of patient contact or CE activity. Individuals recording patient contacts that do not identify a BCAS or WCB reference number must ensure that evidence of the event can be provided. For CE activity, either transcript, certificate or course receipt will provide sufficient proof. If this documentation is not available (e.g. internal training provided) then the CE Documentation Form should be completed and retained.

Patient Contacts

Patient contacts refer to activity where registrants licensed by the Board interact with patients in the course of active EMA practice. This includes contacts while functioning with BCAS, in industry or in a hospital position where there are opportunities to assess and to apply protocols and procedures to patients in a pre-hospital care setting.

Each registrant must record a minimum of 20 patient contacts per calendar year, but all registrants are encouraged to log as many calls as they wish . It must be stressed that it is the quality and variety of calls, not just their number, that are the key influences in determining if an evaluation may be required upon license expiry.

Experiences as attendant, driver, or escort are all eligible for consideration as patient contacts. Registrants are encouraged to record patient contacts from throughout the year rather than all from one time period.

Please submit patient contact information using the Patient Contact Submission Form. The form utilizes drop down menus for easy entry of function, type of patient contact, and skills information. Multiple contacts can be recorded on one form. Once the form is complete, click on the "Submit Form" button. This will submit patient contact information electronically to EMA Licensing.

CE as a Supplement for Patient Contacts

The minimum number of patient contacts is 20 per calendar year. However, if a registrant is unable to obtain the required number of contacts, completion of additional CE may be accepted as an alternative. CE accepted for this purpose will be in addition to credits required for satisfying minimum CE requirements.

Individuals who have not had 20 reportable patient contacts in for the reporting year, may transfer excess Continuing Education (CE) credits earned as a one for one substitution for the number of additional patient contacts they require. CE credits can be transferred to your Patient Contact requirement, by completing and electronically submitting the Request to transfer CE Credits form.

Although annual patient contact requirements can be maintained with a combination of patient contacts and CE, a licensing evaluation will be required prior to issuing a replacement license after five years if the registrant does not achieve at least 20 patient contacts each year.

Continuing Education (CE) Requirements

Registrants are required to attain and report activities worth a minimum of 20 CE credits each calendar year. Reporting can be done either periodically throughout the year or all at one time. The deadline for reporting is no later than January 31st of the following year.

Note that for 2005 and 2006 only, registrants are required to attain 30 CE credits for the combined two-year period and report this activity no later than January 31, 2007.

Similar to providing patient contact information, the CE web forms are used to submit CE activity completed. While there is no limit on recording CE credits each year, there is no opportunity to carry credits over to subsequent years.

What is CE Eligible?
A wide variety of CE activities are eligible for credits. The Approved Credits list and CE Submission Form (Approved training) indicates the courses and their assigned credits. Please note that this is not a comprehensive list of activities.

Training agencies can be of assistance in finding CE eligible course offerings and activities. Some activities can be repeated each year and receive full credits each time. Other activities may only be recognized once or limited to one or two times per five-year license cycle.

Note that although some activities may include elements of emergency care or transfer knowledge that could potentially be helpful during active practice, they may be deemed to have a primary focus that is decidedly non-medical emergency related, and therefore, not eligible for CE credits.

How to Submit for CE Credits
Please submit your CE information after you have completed your education using the forms provided. Once you have completed the form, click on the "Submit Form" button. This will submit your CE information electronically to EMA Licensing.

- ⇒ Use the CE Submission Form (Approved Training) form if the course or activity has been pre-approved by EMA Licensing (i.e. included in the course name drop-down list in the web form:
- ⇒ Use the CE Submission Form (Request for approval of CE Activity) form if the course or activity does not appear in the course name drop-down list in the above web form:
- ⇒ Use the CE Documentation form to retain a copy of your CE activity for your records. It is useful if the course does not provide any certificate of completion. This form can also be used to complete and submit CE information by fax.

Alberta
(the following information was obtained directly from the Website of the Alberta College of Paramedics. www.collegeofparamedics.org

During an e-mail conversation to obtain further detail the college indicated that the comparison detail we were hoping to obtain may be considered proprietary. Anything viewed as 'public information' is on their website. Numerous requests have been received from other provinces and territories who would like to model after Alberta's processes, and when the College considers the money spent on specialists and legal consultants etc. to develop them processes, they felt an 'information sharing' fee should being considered. Discussions are currently underway)

Annual requirements

- ⇒ Alberta Occupational Competency Profiles (AOCP) for the three levels of paramedic practitioners (Emergency Medical Responder, Emergency Medical Technician, and Emergency Medical Technologist - Paramedic) were created in consultation with Alberta

Health and Wellness. The Alberta College of Paramedics (ACP) approved the AOCP document as the "scope of practice" for the three levels of paramedic practitioners in 2002. Training modules, commonly referred to as "GAP Training" were then developed. ACP has required practitioners who graduated prior to 2004 to successfully complete this additional training by June 2006. With the cooperation of Educational Institutions, students enrolled post 2004 have been trained and examined to the new scope of practice.

The following are the education criteria set out by the Alberta college of Paramedics for registration renewal:

⇒ CPR/ACLS – EMR's and EMT's must submit confirmation of current certification of Basic Rescuer – Level C CPR. Certification must be current within the pervious 2 years

⇒ EMT'P must submit confirmation of current certification of ACLS. Certification must be current within the pervious 4 years.

License evaluation

⇒ Please refer to Continuing Education heading

License review

⇒ Please refer to Continuing Education heading

Documentation and Audit process

⇒ It is the individuals responsibility to maintain documentation. Individuals are selected at random to show proof CME activity

Patient Contacts

⇒ Identification of Primary area of responsibility

⇒ Estimated patient contact hours

Patient contact submission form

CE as a supplement to patient contacts

⇒ Professional development hours (in house, Seminars / work shops, conferences)

Continuing Education

Please note that "Continued Competency" is a different concept from "Continuing Education". Continuing competence programs also include the requirement to be "current in practice", which most often means a certain number of practice hours in a specified number of years. Members will be provided with flexible options in how they choose to maintain their competencies.

⇒ Continuing Competency program – Under the *Health Professional Act*, the Continuing Competency Program will replace the requirements for completion of Con-Ed Modules and verification of employments hours. Regulated members will no longer be provided with annual continuing education modules for mandatory completion. Based on each regulated members Continuing Competency Self Assessment they will be required to complete only the competency areas that they have identified as a learning need.

What is CE Eligible

⇒ The Competency Profile describes the vast expanse of competencies in Alberta at the present time as well as additional changes in scope, which are identified in the Upgrade "Gap" Training Program. Each module in the "Gap" Training Program covers the additional competencies for a specific Competency Cluster as identified in the AOCP for each of the three disciplines regulated by the College. The AOCP includes the knowledge, skills, attitudes, and judgments related to a variety of roles held by registered practitioners of the College.

How to submit for CE credits

⇒ A re-registration logbook has been developed to track re-registration requirements.

⇒ The confirmation of completion of GAP training forms are to be completed by the practitioner, signed off by the instructor and Medical Director and returned to the College

Approved Credits

⇒ The College plans to develop a library of Con-Ed modules which will be available to address learning needs that have been identified through completion of the continuing Competency program.

Ontario

(The information used in the following section was obtained through an telephone interview with a trainer with Fanshawe college and member of the College Steering committee for education (www.ontariocollegeofparamedics.ca) and the Ambulance Act www.e-laws.gov.on.ca available from the Ontario Ministry of Health, Emergency Health Services Branch Website.

Annual
Ontario's EMS personal is currently not self regulating; they are governed by the Ambulance Act through the Emergency Health Services Branch of the Government. Certification is obtained and maintained through EHS and the base hospital network. Physicians are designated by region to oversee quality assurance and annual recertification

Provincial Maintenance of Certification
Upon completion of a recognized Paramedic Training Program, a paramedic must maintain certification as per the *Ambulance Act*

Annual
Maintenance of Certification requires that the Paramedic:

⇒ Be employed by an Emergency Medical Service and work as a Paramedic, and/or Paramedic Preceptor, and work for a minimum of 144 scheduled hours in the previous 12 months in an acute care medical environment, with an absence from clinical activity of no longer than 90 consecutive days.

License Evaluation
If certification criteria are not fulfilled, an evaluation may be initiated by the Medical Director to ensure competency in the skills the paramedic has been certified to perform. This will include, but not be limited to:

⇒ Proof of reasonable attempts to complete 144 scheduled hours of emergency medical experience.

⇒ Documentation of practice of skills overseen by the Base Hospital.

Documentation

⇒ Meets all Base Hospital administrative requirements including completion and submission of forms and successful completion of all Base Hospital Continuing Medical Education (CME) requirements as outlined in the Provincial Base Hospital Standards.

Continuing Education

⇒ Credit for equivalent learning will be at the discretion of the Medical Director. If a Paramedic is absent from CME, the Paramedic is responsible for contacting the Program Director to make arrangements to successfully complete the CME objectives.

⇒ Demonstrates competency and adherence to standards, protocols and legislation associated with the performance of Controlled Acts and the provision of patient care at their level of certification. This will be determined through Base Hospital Continuous Quality Improvement (CQI) initiatives. They may include, but are not limited to:

⇒ Chart Audits

⇒ Peer Review

- ⇒ Rideouts
- ⇒ Dispatch/Base Hospital Physician Communication Review
- ⇒ Patch/Communication Review
- ⇒ Field Performance Evaluation
- ⇒ Successful Performance at CME
- ⇒ Review of Skills Inventory

If at anytime in the judgment of the Base Hospital Medical Director, conditions have not been maintained, the Base Hospital Medical Director may deactivate/decertify the Paramedic. The employer will be notified and the employer and paramedic will be given written notice by the Base Hospital. Upon receiving notification from the Base Hospital, the employer will notify the Paramedic verbally and without delay that they are to immediately contact the Base Hospital. The Paramedic will not be authorized to perform Controlled Acts while they are deactivated/decertified. The conditions for reactivation/recertification will be determined by the Base Hospital and should be completed within two weeks of notification, unless agreed to by the Ambulance Service Provider and the Base Hospital. The conditions will be communicated in writing to the Paramedic.

The Paramedic Conduct Directives will apply whenever paramedics participate in on-duty assignments or duties related to the certification processes endorsed by individual Base Hospital Programs. These Directives will be routinely evaluated and uniformly enforced by the employer and the Base Hospital.

It was Mercury's understanding, at the time of writing this report, that all base hospitals in the network develop their own 'system' for recertification although the end result must align itself with the requirements in the Ambulance Act. We were able to access the following outline and have chosen to use this as a ***generic example***, it may or may not be a similar procedure to other base hospitals.
The Sudbury Base Hospital Paramedic Program (SBHPP) annually evaluates each Paramedic's skill through written evaluations and Objective Structured Clinical Evaluations (OSCEs). Successful completion of this process is a requirement for recertification.

Primary Care Paramedic evaluations will include six (6) components:

- ⇒ Written Symptom Relief exam consisting of a minimum 25 questions
- ⇒ Written Defibrillation exam consisting of a minimum 25 questions
- ⇒ Four (4) OSCE style scenarios
- ⇒ Advanced Care Paramedic evaluations will include seven (7) components:
- ⇒ Comprehensive written evaluation consisting of a minimum 50 questions
- ⇒ Written ECG interpretation exam consisting of a minimum 10 rhythms
- ⇒ Written medical math exam consisting of a minimum 15 questions
- ⇒ Four (4) OSCE style scenarios

License Evaluation

A Paramedic is deemed successful if they pass all components of the recertification testing session. A Paramedic who is deemed unsuccessful in only one (1) component of testing will NOT BE deactivated. The Paramedic will either:

⇒ receive remediation on the day of testing, or

⇒ be required to repeat the component at the Sudbury Base Hospital no sooner than one (1) week and no longer than three (3) weeks from the first attempt. The Paramedic will be responsible for coordinating a mutually agreed upon time with their respective Coordinator. The Medical Director or Coordinator will make this decision.

Nova Scotia

(The information used in the following section was obtained through an e-mail interview and subsequent documents provided by the Registrar, Emergency Health Services Department of Health. www.gov.ns.ca

The e-mail correspondents indicated that the (Paramedic) Association was no longer in effect in Nova Scotia. They indicated that Nova Scotia is currently in the initial stages of development of the College of Paramedics of NS. The Paramedic Act has been passed and they were now in the process of laying the ground work. The registration process is changing effect January 1, 2007; the document should be considered draft.)

Annual requirements

Re-registration process is changing as of January 1 2007. The following information is considered DRAFT and not currently used for licensing.

⇒ Clinical – it is the paramedics responsibility to submit the current required number of patient contacts to the registrar – 1 credit per patient contact – Minimum of 10 Contacts required – Maximum of 20 patient contacts

⇒ Self learning activities - 1 credit per hour – Minimum of 5 credits– Maximum of 10 credits

⇒ Group learning activities – 2 credits per hour – Minimum of 6 credits – Maximum of 46 credits

⇒ Certifications

⇒ Approved Course Providers:

Canadian Red Cross / Heart & Stroke Foundation / St. John's Ambulance / National Academy of Emergency Medical Dispatchers/ Emergency Care & Safety Institute (used to be National Safety Council.

2 Credits Per Hour *Minimum of 8 credits* Maximum of 32 credits

Formal Courses (provider or instructor): ACLS, BTLS, EMD, EMDQ, NRP, PedALS, PHTLS

16 hours or 32 credits

Refresher / Recert Courses (provider or instructor): ACLS, BTLS, NRP, PedALS, PHTLS
8 hours or 16 credits

- BLS-C/CPR(C) Formal Course (provider or instructor):
  16 hours or 32 credits
- BLS-C/CPR(C) Refresher / Recert Course (provider or instructor):
  4 hours or 8 credits
- Re-certifications:
  BLS/CPR provider or instructor - re-certified every year
  ACLS - re-certified every 2 years
  BTLS - re-certified every 3 years
  NRP - re-certified every 2 years
  PedALS - re-certified every 2 years
  PHTLS - re-certified every 3 years

- EHS Approved Preceptor Program/Workshop
  8 hours or 16 credits

⇒ Interactive Learning activities minimum of 6 credits – No maximum credits

- Megacodes: 2 Credits each
  All registered Paramedics must complete a minimum of one (1) successful Megacode per re-registration period.
- M&M's: 2 Credits each
  All registered Paramedics must complete a minimum of two (2) M&M's per re-registration period.
- Other: 2 Credits per hour
  Mock Disasters
  Objectively Structured Clinical Evaluation (OSCE)
  Simulation Sessions
  OR Airway Management Session with documentation

⇒ Professional Development – Teaching Research or Committee work
2 credits per hour – no minimum credits – no maximum credits

License evaluation

⇒ Information not currently available

License review

⇒ Information not currently available

Documentation and Audit process

⇒ It is the individuals responsibility to maintain documentation.

⇒ Individuals are selected at random to show proof CME activity

Patient Contacts

⇒ A document has been developed to track this process. Documentation available upon request

CE as a supplement to patient contacts ?

⇒ Information not currently available

Continuing Education

What is CE Eligible

How to submit for CE credits

⇒ A re-registration logbook has been developed to track re-registration requirements.

⇒ A list of approved training programs has been developed and is available from the EHS registrar for a specific course or in the EHS protocol binder located at each base location

⇒ The Continuing Education Unit (CEU) form is to be forms are to be completed by the practitioner , signed off by the instructor and returned to the registrar, Emergency Health Services

Approved Credits

⇒ A list of approved training programs has been developed and is available from the EHS registrar for a specific course or in the EHS protocol binder located at each base location

North Dakota

(The following outline was obtained from the North Dakota Department of Health Emergency Medical Services Website. It outlines training, testing and certification Requirements for EMS personal. An e-mail interview was also conducted. All the information was obtained through these sources.)

The National Highway Traffic Safety Administration (NHTSA) has assumed responsibility for the development of training courses that are responsive to the standards established by the Highway Safety Act of 1966 (amended). The training courses are designed to provide national guidelines for training. There are several report and studies available outlining the proposed process. These include: *Emergency Medical Services Education Agenda: A Systems Approach* available on-line at www.nhtsa.gov.

Annual

North Dakota is a National Registry state. They use a National Certification agency to certify all levels of pre-hospital care providers. These levels include EMT-Basic, EMT-Intermediate and EMT-Paramedic. The certifying agency that is used is the National Registry of Emergency Medical Technicians in Columbus, Ohio. They are required to become registered through this agency before they can apply for licensure here in North Dakota.

The Division of Emergency Medical Services of the North Dakota Health Department issues licenses to these providers once the certification has been met. In order to do this they must have a signature from a ND licensed physician and the licensure is good for two years. Providers must also follow protocols that fall within the scope of practice. The scope of practice is listed on state EMS website but not protocols since it is the responsibility of the physician to determine what the pre-hospital provider can and cannot do on their own service.

The following websites can be used to obtain specific information;

National Registry website: www.nremt.org

ND department of Health: www.ndhealth.gov/EMS/

First Responder

Persons certified as first responders typically render care to the sick or injured while an ambulance is enroute. First responders usually are members of an organization (i.e. Quick Response Unit, Fire Department or Law Enforcement Agency) that are dispatched simultaneously with an ambulance service.

- ⇒ Training Time: 40 Hours.
- ⇒ Curriculum: US DOT Emergency Medical Services: First Responder Training course.
- ⇒ Testing: Practical examination consisting of at least one medical, one trauma and one cardiopulmonary resuscitation station. Written examination (70% score or higher).
- ⇒ Certification Period: Two years adjusted to a June 30th expiration date.
- ⇒ Recertification: Complete a sixteen-hour ND First Responder Refresher Course, a 24 hour EMT Basic Refresher Course, or audit certain lessons of a full EMT-Basic Course.

Advanced First Aid Ambulance

The Advanced First Aid Ambulance Certification was created as a mechanism to grandfather persons as ambulance attendants who were previously certified under the discontinued American Red Cross Program. Persons who were certified by the American Red Cross as Advanced First Aid Providers, possess current CPR certification and have at least two years of ambulance experience are eligible to be certified by the North Dakota Health Department as Advanced First Aid Ambulance. This process only exists for persons trained by the American Red Cross prior to their discontinuance of their training and is not available for training new ambulance attendants. New ambulance attendants must complete an EMT-Basic training program.

- ⇒ Certification Period: Three years.
- ⇒ Recertification Requirements: Twenty-four hour EMT-Basic Refresher course.

Emergency Medical Technician

The Emergency Medical Technician (EMT) is the North Dakota equivalent of a National Registry Emergency Medical Technician. North Dakota issues an EMT licensure to persons under the age of 18 who do not meet the minimum age requirement for National Registration and to persons who apply for reciprocity from another state. All of the training, testing, certification, and licensure requirements are identical to an EMT-Basic.

- ⇒ Training Time: One hundred and ten hours.
- ⇒ Curriculum: US DOT Emergency Medical Technician - 1995.
- ⇒ Testing: National Registry Practical and Written Exams.
- ⇒ Initial Licensure: Two years adjusted to June 30.
- ⇒ Recertification Requirements: Forty-eight hours of continuing education, 24 hour EMT-Basic refresher course which includes CPR recertification.

Emergency Medical Technician - Basic

The Emergency Medical Technician-Basic (EMT-B) licensure is considered the minimum training level for Basic Life Support ambulance attendants. Many other occupations utilize the training to augment their services. Some examples include athletic trainers, security personnel, law enforcement officers and firefighters. North Dakota utilizes the National Registry of Emergency Medical Technicians (NREMT) certification standards and then will issue a state license.

- ⇒ Training Time: One hundred and ten hours.
- ⇒ Curriculum: US DOT Emergency Medical Technician - 1995.
- ⇒ Testing: National Registry Practical and Written Exams.
- ⇒ National Registry certification dates adjusted to March 31, Initial State Licensure: Two years adjusted to June 30.
- ⇒ Recertification Requirements: Forty-eight hours of continuing education, 24 hour EMT-Basic refresher course which includes CPR recertification.

Emergency Medical Technician - Intermediate

The Emergency Medical Technician-Intermediate (EMT-I) certification level is typically utilized by ambulance services providing limited levels of advanced life support care. The course expands upon the EMT-B through inclusion of advanced patient assessment, airway management and intravenous therapy skills.

- ⇒ Training Time: One hundred hours (in addition to the EMT-B training).
- ⇒ Curriculum: US DOT Emergency Medical Technician Intermediate National Standard Curriculum.
- ⇒ Testing: National Registry Practical and Written Exams.
- ⇒ National Registry certification dates adjusted to March 31, Initial State Licensure: Two years adjusted to June 30.
- ⇒ Recertification Requirements: Thirty-six hours of continuing education, 24 hour EMT-Basic refresher course which includes CPR recertification and 12 hour EMT-Intermediate refresher course.

Emergency Medical Technician – Paramedic

The Emergency Medical Technician-Paramedic (EMT-P) certification level is typically utilized by ambulance services providing full levels of advanced life support care. The course includes invasive procedures such as endotracheal airway management, defibrillation, pharmacology and other advanced skills.

- ⇒ Training Time: One thousand hours (in addition to the EMT-B training).
- ⇒ Curriculum: US DOT Emergency Medical Technician Paramedic National Standard Curriculum.
- ⇒ Testing: National Registry Practical and Written Exams.
- ⇒ National Registry certification dates adjusted to March 31, Initial State Licensure: Two years adjusted to June 30.
- ⇒ Recertification Requirements: Twenty-four hours of continuing education, 48 hour EMT-Paramedic refresher course, and current CPR and ACLS certification.

Australia

(The following information was obtained through an e-mail interview with a Director of the Annual Registry of Emergency Medical Technicians Australia).
http://www.acap.org.au/index.php
http://www.ambulance.qld.gov.au/recruitment/priorqual.asp
There is no comprehensive overview document currently available.

Annul requirements for license maintenance

Australia generally has no licensing body but has services as AREMT(Annual Registry of Emergency Medical Technicians) and the Australian College of Paramedics.

- ⇒ License review is conducted from every one to three years depending on location.
- ⇒ Generally, up to 24 hours refresher training, with a combination of 50% practical and online CEUs. Most services in Australia, are run by state health departments, not standard as NREMT requirements. Most services would require the same for their Paramedics.

License evaluation

Annual clinical and ambulatory practice with inservice training.

License review

Annual clinical and ambulatory practice with inservice training.

Documentation:

- ⇒ Ambulatory (Diploma in Para Science as minimum)
- ⇒ Records of CEU by approved RTO (Registered Training Organizations) or in service training by ambulance services, who are also Registered RTOs as well.

Patient contacts and submission forms:

⇒ Clinical practice records/logbooks. Ambulatory provide their own, AREMT has just put together a clinical/CEU/EMT logbook for proof of skills.

How it supplements continuing education:

⇒ We have no set CE requirements, but AREMT has put in place up to 24 hours-50 hours dependent upon EMT level.

Continuing Education
What is CE eligible:

⇒ In Australia, generally any approved RTO that provides health training packages, nursing or ambulatory training modules. Hospitals and clinics that are approved by state health and ambulance services. A variety of International EMS/Health CEU providers that are recognized; i.e UK(RCS)AAOS.

How do you submit for CE credits:

⇒ Simply that records of attainment need to be kept, and verified by RTO providers or workplace assessors.

⇒ Each ambulance services has there own setup, no standard submission. (An outline of approved credits will be provided upon request)

Delivery processes

⇒ Delivery process for initial/refresher is classroom/practical, with some pre and post course online and self paced study. i.e. EMT Certificate IV level (308 hours nominal) Diploma in Para Science (1080 hours nominal).

Saskatchewan Nursing Continuing Education
(The following information was obtained from the SRNA website www.srna.org and through an e-mail interview.)

SRNA (Saskatchewan Registered Nurses' Association) has over the course of the last several years moved from a system that required completion of continuing education units to the Continuing Competence Program which is a self-assessment and self-development program. The program, with input from SRNA members, was designed to allow a wide variety of learning activities based on individuals learning style and particular needs within their area of practice.

Continuing competence is defined as the ongoing ability of an RN and RN(NP) to integrate and apply the knowledge, skills, judgment and personal attributes required to practice safely and ethically in a designated role and setting, personal attributed include but are not limited to attitudes, values and beliefs (adapted from the National Task Group on Continuing Competence – 2000).

Annual requirements

SRNA bylaws specify that individuals are required to practice as an RN a minimum of 1125 hours in a five year period prior to the year that registration is sought. In addition to participating in a Continuing Competence Program RN (NP) licensure requires 1800 hours of nurse practitioner recognized practice in three years.

Every year RN's and RN(NP) are expected to complete a self assessment, engage in peer feedback, complete a learning plan which includes a timeline to meet priority learning needs for that registration year and provide evidence that learning needs have been meet. The learning plan may identify some learning needs and associated educational or experiential activities that take more that a year to complete. The practitioner should identify priority learning needs that should be met each year. Records should be kept for a minimum of 5 years.

Documentation and Audit Process

RN (NP) will not be required to submit documents as a part of the annual registration. Starting December 1 2007 RN (NP) will be required too declare on their annual registration renewal form that they have completed each component of the program. A random sampling of RN's will be audited annually to verify compliance with the program. If part of a annual audit the RN will be required to submit documents. The frame work for the audit process is being developed and may include the following:

- ⇒ Partial document review
- ⇒ Interviews
- ⇒ Completion of a survey
- ⇒ Submission of documents

Continuing Education Requirements

There is no fixed number of learning activities. The number of activities in the self directed plan will be directed by the self assessment of an individuals practice.
While the individual RN or RN (NP) has the professional and primary obligation for continuing education the employer also has a responsibility to support RN employees. This can be accomplished by talking to staff about learning needs and appropriate learning activities that could enhance practice.

How to submit for credit

RN and RN(NP) will use the RN's Continuing Competence Program Workbook as a resource a tracking tool for their self directed learning process. This document does not need to be submitted unless the RN or RN (NP) is subject to audit

APPENDIX II.

FOCUS GROUP MODERATORS GUIDE

Focus Group Moderator's Guide

Introduction

1. Introduce the client, the moderator, and Mercury Information Services. Thank participants and introduce the topic for discussion: development of a Continuing Medical Education framework within the emergency medical services sector

2. Explain the function of focus groups.

3. There are no correct answers – only your opinion. You are speaking for many other decision makers like yourself.

4. The goal of the focus group is not to gain consensus in the group so it is important to hear from everyone. Don't worry if your opinions differ from others in the group.

5. Discussions should be carried out with one person speaking at a time – no side discussions please. I'm afraid I will miss some important comments.

6. The focus group will be audio taped, which will allow me to concentrate on what you are saying rather than taking notes. This will allow us to transcribe the results of the focus group for further analysis. All of the information collected today will be confidential. Your names will not be used.

7. I will not be offering *my* opinions during the discussion. It is more important to hear *your* feelings and opinions.

8. Have all participants introduce themselves and their organization.

9. Any questions before we begin?

Overview

The Saskatchewan College of Paramedics (SCP) formerly the Saskatchewan Paramedic Association (SPA) has entered into Phase II of the Sector Partnerships project with SaskLearning and SaskHealth. Phase I was a broad based project that identified general industry issues in Saskatchewan. Phase II will address specific issues identified in Phase I particularly continuing medical education.

As a part of the Phase II process a working group of industry members has been brought together to develop a new 'draft' framework for CME in Saskatchewan. To assist this group with their task a literature review providing an overview of Continuing Medical Education models and practices at a provincial, nationally and internationally level as well as interdisciplinary levels was completed. Continuing Medical Education is mandatory in Saskatchewan but the content is at the discretion of the employer/trainer/facilitator. The SCP believes that it will become a self regulating body early in 2007; when this becomes a reality the model should be in place. This project will take the current framework, expand and enhance it so that it can be put in place when the anticipate legislation becomes reality in 2007.

For this draft framework to be most effective the input of practitioners is imperative. To this end we are holding 10 Focus Groups (5 with Employees and 5 with Employers) throughout the province in the November of 2006. The information from the FG's will be summarized and presented to the sector working group to assist them in their work on the proposed CME model.

1. **Minimum number of patient care contacts**

In your opinion should patient contacts be tracked as a part of licensure? Why or why not?

If yes, how many contacts should be required?

What type of contact should be required? (Quality vs. Quantity)?

Should some contacts be mandatory? Please give examples.

2. **Written evaluation of skill sets**

It has been suggested that a 'before and after' quiz be administered to learners to assess, not grade, the level of understanding the learner may have of any given Continuing Medical Education (CME) topic.

In your opinion, would this be a useful way to assess the learner's knowledge before and after a CME session? Yes/No please explain?

If modules were provided to you to read through on your own time that included a quiz at the end would you find this be an acceptable way of monitoring the CME process.

What other methods might be used to benchmark the learner's knowledge? Please explain.

3. Simulation

In your opinion are simulations an effective learning tool? Why? Why not? Please explain.

If yes, what would your learning expectations be? Please explain.

4. Approved credit list

Some jurisdictions have an approved credit list. Who, in your opinion should decide what credits are appropriate for the list? Please explain?

What criteria would you use to determine acceptance.

5. Facilitator model with shift towards practitioner ownership

Saskatchewan currently uses a facilitator model to track and monitor CME. Is this, in your opinion, an effective method? If yes please explain.

If no, what other methods would be equally or more effective? Please explain?

6. Modules for CME

Some CME credits have been developed in a modular system. What, in your opinion, would be the best way to deliver these modules? Some examples would be DVD, telehealth, internet. Please give examples and explain.

7. **Inter agency sharing of Continuing Medical Education information (telehealth)**

   It has been suggested that CME information be centrally stored and accessed by the learner or educator depending on need.

   Do you believe this would be an effective way to ensure that information is available to all regardless of location? Why or why not. Please explain.

8. **Transparent layout of requirements**

   What type of information would you like to receive regarding CME requirements? Please explain. (Prompt…how much information, how often and in what format)

In closing, I would like to ask if you have any additional comments.

Thank-you for your time!